MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, N.W.
Washington, D.C.

Friday, January 14, 2000
9:08 a.m.

COMMISSIONERS PRESENT:

GAIL R. WILENSKY, Ph.D., Chair
JOSEPH P. NEWHOUSE, Ph.D., Vice Chair
BEA BRAUN, M.D.
SPENCER JOHNSON
PETER KEMPER, Ph.D.
JUDITH R. LAVE, Ph.D.
HUGH W. LONG, Ph.D.
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JANET G. NEWPORT
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ALICE ROSENBLATT
JOHN W. ROWE, M.D.
GERALD M. SHEA
MARY K. WAKEFIELD, Ph.D.

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P R O C E E D I N G S

DR. NEWHOUSE: Could we get started? We have a lot to do today. Gail is on her way in. We'll start with Anne Mutti talking about prescription drugs and the Medicare population.

MS. MUTTI: I would just direction your attention to Tab F for a couple of the proposed outline and workplan for the chapter that we're suggesting for the June report. What I was planning to do was to walk through the outline and present some initial data that serves as an introduction to the issue and an example of the type of analysis that we're proposing in a series of about eight slides intermingled in the discussion of the outline. Then by the end of the presentation and our hour here, or however much time we have, I'm hoping to get a sense from the Commission as to how you would like us to proceed.

I have here with me Roland McDevitt, who is the director of health research for Watson Wyatt Worldwide, which is a benefits consulting firm. They have helped but together the slides for us. And while I will be doing the presentation, for logistical ease, he is here to answer any questions that you might have and provide more information.

Overall, this workplan is intended to produce an analytic, objective piece that presents background data and identifies some of the policy questions that should be considered when assessing various options to expanding prescription drug coverage to the Medicare population. This outlines assumes the Commission will not make recommendations on this issue at this time.

As part of the introduction we would note the reasons why MedPAC would be considering this issue now. Staff would suggest that those reasons include that we've gotten several requests from congressional staff for technical support on this issue. It does build on earlier work that we've done both in beneficiary liability issues as well as the range of coverage that's provided in the Medicare+Choice plan. Then also while the timing of any consideration or action on this issue may be questionable, it certainly could help the Commission at this point to just have an introduction and some initial consideration on the issue.

The next part of the outline which is Section number 2 is where we propose that staff produce, through either our own original research or through collecting

research from other sources that's available out there, a range of data on beneficiary spending for prescription drugs, available insurance coverage, and trends in both those areas, both coverage and spending. It also proposes exploring issues such as the substitution between drugs and other medical services, the impact of lack of insurance on access to care and compliance with doctor's orders.

We would also propose to look at trends in employer retiree drug coverage benefit design. They're the largest source of coverage right now. It might be interesting to look at what they're doing in the way of coverage and how they're containing costs. Lastly, we thought we might provide a review of previous experience with expanding coverage for the Medicare population in both the catastrophic act and also the health care reform act in the early '90s.

At this point I was hoping that we could just turn to some of the slides so we could give you an idea of what we were thinking of in terms of the background data. On the first slide, this chart illustrates the rising cost in 1998 dollars of medical costs that are not paid by Medicare. That means this includes expenses that were paid either out-

of-pocket by beneficiaries as well as by supplementary insurance sources, and that would include Medicaid. This chart shows that prescription drug costs are the fastest rising component and have doubled in the past 10 years.

In 1999, Wyatt Watson estimates that the per-beneficiary drug spending averages around $1,000 per person. While we haven't done estimates for the future here, even using conservative estimates of prescription drug costs we might think that that would even grow considerably more in the next 10 years.

DR. LAVE: Could I ask a question about that? Given that a significant proportion of Medicare beneficiaries actually have drug coverage, for those people who don't have coverage the average cost is going to be about $2,000? Do you have any sense for --

MS. MUTTI: We have a slide coming up a little later that gets at the spending patterns of those with and without coverage.

On the next slide, this is basically the same data but just expressed as a percent of income. This is a measure that we've used in the past to measure beneficiaries' financial liability. As you can see, the

medical expense not paid by Medicare is rising considerably faster than the mean income for the aged population, especially for prescription drugs since 1988.

DR. NEWHOUSE: Is this averaged over persons or what?

MR. McDEVITT: Yes, it's averaged over per capita income for the post-65 population. It's the P-65 series from CPS.

DR. NEWHOUSE: But my question is, is it averaged for everybody or you took each person's percentage and then averaged that?

MR. McDEVITT: It's basically all of the dollars for drugs divided by all the dollars for income.

MS. MUTTI: I think there's two ways to do this calculation and one results in a higher percentage. We've averaged it across all persons so it ends up being a little lower. You probably have seen other numbers which are higher and it's just a methodological issue. Both are correct.

MR. SHEA: Just a question on what's included in the other medical.

MR. McDEVITT: The other medical basically is

normally what you'd think of as Medicare-covered services that are not paid by Medicare. It also includes some services that are not covered by Medicare like preventive care and things of that sort. Basically what we did here is we have a microsimulation model that we've developed for use with employers in valuing their retiree medical plans, and it's run off of a gross claim; the total dollars that are generated in physician visits and other care. Then we take out the Medicare component and what's left is what you see here.

MR. SHEA: But this would include out-of-pocket for covered services, right?

MR. McDEVITT: Yes.

MR. SHEA: And also Medigap insurance?

MR. McDEVITT: Yes.

MS. RAPHAEL: Does it include long term care?

MR. McDEVITT: No, it doesn't.

DR. ROWE: Does it include durably medical equipment?

MR. McDEVITT: It basically includes all acute care services and prescription drugs. So in broad terms, it's things that are generally covered by Medicare and

prescription drugs. Prescription drugs are on the top part of the bar though.

MS. MUTTI: On the next slide we present a distribution of prescription drug spending for Medicare beneficiaries based on MCBS data. As you can see in this estimate about 14 percent had no prescription drug expenses while about 31 percent had over $1,000 a year with 6 percent spending over $3,000 a year.

DR. ROWE: Now this includes the disabled and end-stage renal disease?

MS. MUTTI: Yes. This is total prescription drug spending so it includes both out-of-pocket and insurance expenses for drugs.

This slide discusses the national prescription drug spending growth trends and factors driving that growth. As you can see we present a range in the projection of the growth from 10 to 18 percent for prescription drugs. I would say HCFA comes in around closer to the 10 percent range for the next 10 years, but we're seeing from the prescription drug benefit managers that they're expecting more in the 18 to 20 percent range actually.

Interestingly, this growth is largely due to the

introduction of new products and then growth in utilization rather than drug price increases for existing drugs. You see there's been about a 3.5 percent average annual CPI increase for the market basket of prescription drugs during 1994 to 1999, so that's 3.5 percent of 10 to 18 percent is just the increase in existing drug prices.

What's really driving it here is the product mix and the new drugs which is driven largely by increased manufacturer R&D, which has produced a lot of new drugs on the market. We've seen an accelerated FDA approval process that addressed both the backlog of new drugs seeking approval and then also means the drugs can get to market faster than they could before.

We're also seeing incredible investment in direct consumer advertising. In a recent article that cited that in 1998 pharmaceutical manufacturers spent $1.3 billion on direct consumer advertising. That was an increase of 55 percent over the previous year.

DR. ROWE: During this period of five years there's been some modest increase in the average age of the Medicare beneficiaries, and drug utilization is strongly related to age. I suspect those 14 percent that have no

prescriptions are disproportionately a younger group than the people who are using more. Is it possible that some significant part of the increase of 10 to 18 percent is not related to some of these items on the bottom of this slide so much as it is just a change in the average age of the Medicare beneficiary? Is your analysis corrected for that?

MS. MUTTI: I think that's picked up in our utilization.

MR. McDEVITT: We've done quite a bit of looking at the phenomenon of aging of the population, how it relates to medical costs. Over this short period, I don't think it's -- it's not a major factor. I think longer term, when you start seeing the ratio of post-65 and pre-65 really changing after 2010, it will be a much larger factor then.

MS. MUTTI: This chart identifies the sources of coverage for prescription drugs now. As you can it's risk HMOs, employers, Medigap, Medicaid, and all other. All other includes VA coverage as well as state pharmacy assistance programs. Then just for reference we've also put the Medicare-only on this chart. This is using 1995 data.

About 65 percent of beneficiaries have coverage; 35 percent do not. As you can see employers were the

largest source in 1995 of coverage followed by Medicaid and Medigap. The risk HMO bar for those with drug coverage may look a little low. Again, this is '95. Enrollment has increased substantially since then, so we would expect that to be a little higher. But of course, sort of a countervailing force is the fact that some of the risk HMOs have started to curtail their coverage and imposed more cost sharing. So where that line is now today we don't really know.

Also evident from this chart is that not all supplementary insurance is equally likely to cover drugs as you can see. Say for example, Medigap, a lot of the people who have Medigap coverage do not have drug coverage. I'd also note, just in case you had any questions about Medicaid, the little bar there that shows those with no drug coverage is for the QMBs and SLIMBs, those low income beneficiaries that do not get the drug benefits through Medicaid; just their cost sharing.

DR. WILENSKY: Anne, is the HMO information available now? I know it was obviously not in the Health Affairs article, but presumably that information is available from HCFA because they know whether there's drug

coverage.

MS. MUTTI: Right, and Scott will be talking about that in his presentation following this one.

This slide, this gets to your point about spending and whether you don't have coverage. As you can see you tend to spend more if you have coverage. I think there are several questions that we would need to look into as to what causes and drives this relationship. There's several things to look at; whether enrollees with poor health status might seek out drug coverage and that's why they're spending more, or whether it is that the mere presence of the coverage means that you're going to spend more.

We might also want to look at issues concerning the role of substitution of lower-cost drugs by those that don't have insurance. They might just be substituting generics and that's why they're spending less. We want to look a little bit more into that kind of relationship.

MR. SHEA: Just a question on this slide before you proceed. Does this capture all spending in each category? For instance, in the employer is this those with coverage, covers both the employer share and the employee share?

MR. McDEVITT: That's the intention. It's basically Medicare current beneficiary survey self-reported and then it's -- there's a lot of data issues here, but conceptually that's what it is.

MS. MUTTI: We've also looked into what we know about those who have coverage and those who don't. While the data does seem to vary a little bit depending on source, it does seem that those people who do not --

DR. NEWHOUSE: Can I go back to the answer you gave before. Maybe this is what you meant by the data issue. But if I go and fill a prescription at the pharmacy I pay $5 or $10 or something and the insurance plan makes up the difference. Now I have no idea what the plan paid for my prescription and my employer only knows, at best, what they paid for a drug benefit over everybody. So how would that employer payment get figured in here?

MR. McDEVITT: My understanding is that MCBS does some corrections on things like that, and they've done a lot of talking with the people at AHCPR on the MEPS survey, and they've done some cross-checking on the quality of data. There are some differences in the data estimates that are coming from AHCPR versus MCBS, but my understanding is

they're doing some filling in or imputing of data that not's -- where the beneficiary doesn't know the answer.

DR. NEWHOUSE: I presume the beneficiary would almost never know the answer if the insurer paid unless it was the old style indemnity plan where they got the bill and then were reimbursed.

MR. McDEVITT: I think that's especially true today. Five years ago it was a lot less true than it is today.

DR. ROWE: On your prior slide with respect to the expenses per enrollee in the Medigap you have about $670 or something like that for those who have prescription coverage and less for those who don't. Is that out-of-pocket or is that total including the insurer's expense?

MR. McDEVITT: That's total. But there's been a lot of trends since 1995, too. We're really more around $1,000 today compared to then.

DR. ROWE: Has there been migration amongst the 10 Medigap policies that have different amounts of drug coverage from none to $1,000?

MR. McDEVITT: My understanding is that, if anything it's harder to get the drug coverage today than it

was then.

DR. ROWE: Harder to buy it?

MR. McDEVITT: Harder to get it, yes.

DR. ROWE: Meaning underwriters aren't available or the premium is higher?

MS. ROSENBLATT: Both. A lot of plans don't offer it any more because the premiums have been so high. The premiums are very high.

DR. BRAUN: The Medigap drug policies are all medically underwritten, so when you need the drugs you can't get a drug policy. If you were fortunate enough to have gotten it before you needed drugs and while you were healthy, then you have it. But if wait until you need drugs then you're going to get medically underwritten out of it.

MR. McDEVITT: The numbers you normally see when you look at Medigap premiums are driven really by people that don't have those policies. There's only about one-third of the people that have any drug benefit and when you average those premiums in with the premiums for everybody else it's down around $1,000. But these premiums are up to $2,500; they're much higher.

MR. JOHNSON: I guess the '95 numbers concern me.

This is like the BBA all over again. If you look at what's happened and what's driving prescription costs in employers, for example, it's only the last two cycles of rate increases for commercial health plans. For example, in Michigan Blue Cross, in our own company in five years we've gone from a $3 copay to a $5 copay, to a 10, 20 headed maybe beyond that, within the last five years. And within the last two years now we're going to be up to 10, 20.

Certainly we've seen that across the board with all employers in Michigan with the exception, Gerry, of the unionized employees, that employers are reducing their drug benefit and the cost is much higher to the employee now. In fact the concept of whether Medicare drives the private sector or the private sector drives Medicare, it's sort of interesting, if you look at '95 data there's no comparison with reality in terms of what's really going on out there in the private sector with drug coverage and how that might influence employers and whether or not they'd even have a drug benefit for a retiree any more at all.

For example, our premiums would have gone up 19 percent. By adopting the new benefit structure, they went up 9 percent. So I think this '95 data business just really

bothers me. I don't know what we can do about it though.

MR. SHEA: I think there probably are some data sources available. We have an association with a project called the prescription drug value project that AHA is in and the AMA was in at one point I know. They're working with one of the pharmaceutical benefit manager groups, I think PCS, which has much more current data.

MS. ROSENBLATT: Gerry, I would agree. I think some of the PBMs actually make their data available. There's probably a cost associated with it, but it would an unbelievable source of data and would give you much more current data.

MR. McDEVITT: The reason we used this 1995 data is it covers the whole population, the entire Medicare population. You're right, the PBM data is very good and we have access to that. But then there's questions about, how is that population different from everybody else? For this first cut we basically were trying to get a look at sources of coverage and quality of coverage and things like that. This is really just some preliminary work that we were doing on it.

MS. MUTTI: So going on, this is just a slide that

compares certain characteristics of those who do not have prescription drug coverage with those who do have coverage. As I said, some of the data does vary a little bit, but the one that we have cited here indicates that both populations tend to have the same health status but they are more likely to be low income -- these are people who do not have coverage -- probably just right above the Medicaid income eligibility line, and that they are more likely to be over 85 than those who do have coverage.

MS. ROSENBLATT: I just have one comment on this slide. My experience has been that with and without drug coverage do not have the same health status at all. Where there's a selection like between Medigap plans you get tremendous adverse selection into the plans that do have drugs. So that first bullet really surprises me.

MS. MUTTI: Yes, that first bullet bothered us too as we were looking into it because we did find different data saying different things and I think it's definitely something we'd like to come back to. You've got a good point.

On the final slide here we try and do a summary of the cost sharing by source of coverage. This slide shows

that there's considerable variation in the cost sharing by the type of coverage that you have. As you can see, across the top of this slide we talk about the annual premium contribution. That is both medical and prescription drug premiums there. Then the remainder are just the prescription drug characteristics of the plan. So the deductible is just for drugs, coinsurance for drugs, and then the benefit maximum is mostly just for drugs.

What we show here is that the HMO option has a relatively low average annual premium, relatively modest cost sharing, but a maximum benefit of $500 to $1,000. These plans are available to about 70 percent of beneficiaries. Most of the managed care plans do have a drug benefit, although as we discussed earlier, the future of these plans and their benefit structure is likely to change, and Scott will talk about that a little bit more later.

The Medigap drug coverage is far more expensive on average and is, I would say, overall a less generous benefit. The premiums can range from $2,000 to $4,500 and that depends on where you live and how old you are also. It has deductible and a 50 percent cost sharing with a benefit

cap of $1,250 to $3,000.

Employer coverage generally requires a substantial premium of $500 to $600 from beneficiaries but the benefits are quite comprehensive. But again, the future of this coverage is a little uncertain. It seems that fewer employers are offering this type of coverage and that increasingly they are putting a cap on their benefits. That while for many companies it has not kicked in at this point, in the future it will, which would mean that beneficiaries would have to spend more out-of-pocket.

Lastly, we have Medicaid coverage there which is relatively comprehensive. But we'd just note that in many states the eligibility for Medicaid is well below 100 percent of poverty level so not everyone is getting the coverage there.

DR. LAVE: Jack and I have been having a sidebar conversation. The question that I have is, I had read someplace that the differences in the premium for getting a good Medigap policy with a prescription drug benefit compared to the same benefits but not prescription drug benefit, that the difference in the premium was about equal to the drug benefit that you actually got. So that a person

actually would be just as smart not buying a drug benefit, put the difference in the bank, collect a little interest and they'd be better off. Now am I right or wrong about that?

MS. MUTTI: I've read the same thing, but I don't have the cite on that.

MR. McDEVITT: From what I've seen the premiums are all over the place. It's very difficult to get a good national number for this stuff because it really is locally based and we don't get a good -- and they're rated differently from state to state. You know, age rating and not age rating, that sort of thing. So I think it's very hard to generalize on that.

DR. ROWE: One of the other features I think that's in the marketplace, as I understand it, is the development of two or three-tiered drug benefits in managed care plans and other places where the amount of payment on the part of the beneficiary depends upon the kind of drug. This is a quantitative analysis rather than a qualitative analysis that we've seen. So that insulin you get or you get plus a couple bucks, but Viagra you're paying yourself or you're paying more for or whatever.

There are different kinds of categories of agents. If you're willing to take a generic then it's cheaper than if you have to get a brand name. I see that there, but that's just generic versus brand as opposed to different formulary or not, different degrees of importance, et cetera.

Do you have anything to say about what you understand to be the trends with respect to that?

MR. McDEVITT: Yes. There's a lot of movement to a three-tier copay structure. For example, United Healthcare's most popular product now has a $10 -- I think it's $5 generic, $10 formulary, and then $30 for a brand that's not on the formulary. Those are all drugs that are in the same therapeutic substitution category. So basically they're not saying that they won't cover certain drugs. But if you want to have the latest drug that's been directly advertised to consumers and it's not on the formulary, it's going to cost a lot more.

I actually met yesterday with United and with Cigna and Aetna the day before. United says that's been very effective at holding their trend down. And I think that's consistent with what we're seeing and what's driving

trend, it's the new sort of high tech drugs that are very expensive. So if you can have the right kind of cost incentives to use other drugs where you're getting rebates and discounts, there is some ability to control it. But it's also very uncertain. As more and more new product comes out it's not clear that that's going to be effective.

DR. WILENSKY: Is the date from the survey of the employer plans that's referenced there, is that basically giving us a pretty good sense of what goes on now, so we're not in as much of a bind with regard to the date issue?

MR. McDEVITT: Yes. The problem with all this data is the variation. That's what I think is a good average. But there are some employer plans where the retiree pays the whole thing. There's a number where the employer pays the whole thing. So on the average I think it's about 30 percent that --

MS. ROSENBLATT: What year is the data, just to follow up on what Gail is asking?

MR. McDEVITT: '99.

DR. WILENSKY: So we are getting a pretty good reflection of what's going on as best you can tell now?

MR. McDEVITT: Yes.

MS. ROSENBLATT: But I think even from '99 to 2000 there's just so much change.

DR. WILENSKY: I know, but let's not be unreasonable.

DR. ROWE: It's only January.

MS. ROSENBLATT: I know but the renewals for January 2000 are coming out and as Spence said, there's really been tremendous -- I'd say if you were to look at the 2000 January renewals, which is when a lot of business renews, the biggest change has been in the drug benefit.

MR. McDEVITT: I think the biggest problem with the employer coverage is you don't really pick it up in a benefit design. It's really the contribution caps that -- about 40 percent of employers have said, we're going to cap our contributions so in the future we're never going to go above that cap. So you may have a rich plan but the employer's contribution to it is not going to pay for it in the future.

DR. WILENSKY: We can try for next summer or next year to go and find out -- I think what we can try to do is to get ourselves acquainted with what is going on in the most recent data. But I think at some point we need to not

place unreasonable requirements on our staff.

But if there's a way to go back to the issue that somebody asked earlier about whether or not this almost conventional wisdom that the difference between the premium and the benefit that you get from drug coverage is basically the value of the drug coverage, if there is any additional work at some point you could do. It is something that has been said, but because of the variation that exists I've always wondered whether it was quite as simple as it was presented.

DR. KEMPER: It's probably true on average.

DR. WILENSKY: I don't even know if it's true on average. It has been said. I just don't know -- I'd like to have somebody --

MS. ROSENBLATT: Can I make a comment on that, Gail? OBRA changed the way carriers were rating. I know that was true for Blue Cross-Blue Shield of Mass when I was there. They used to have a without-drug program and a with-drug program, and the without-drug coverage was rated across the entire risk pool. Then the drug plan got just the actuarial value of the drug coverage. When OBRA came out, OBRA said you had to rate each risk pool that selected that

plan or within that risk class. So all of the adverse selection of the people that were taking the drug benefit went to the price of that plan and it really drove up the premiums of the plans with drugs.

So my guess is that the reason that you're hearing this kind of thing is that I would say it probably even cost more for some people than the drugs that they buy because of the adverse selection of that class.

DR. ROWE: I think it would be really helpful, to me at least, to have a kind of appendix about the Medigap program and the drug issues within the Medigap program as part of this work and as up to date as it can be. I think that would be very helpful.

MS. ROSENBLATT: I'd just add that I think what would be very helpful would be some comment about the lock-in of the plan design in the Medigap plans prevents the ability to do what is being done by employers in the commercial sector where you're changing and putting in formularies and doing all that kind of stuff which cannot now be done on the Medigap plans.

DR. KEMPER: Can I just follow up on Jack's comment of a minute ago? The distinction between life

critical drugs and other drugs, it strikes me that that's a big issue in thinking about this is what's the covered benefit particularly -- it's one thing for the digoxin prescription, but if you're getting the latest fungicide for your athlete's foot there might be a different structure. I didn't quite understand your response to that question in terms of what's the private sector doing in terms of covered benefits.

MR. McDEVITT: For the most part I'd say the private sector is covering things that are prescription drugs. There's been a lot of brouhaha about Viagra and some of these things, but there's very broad coverage. In contrast, if you looked at Italy and France, they really have gone down this road of trying to set some priorities on what are the most essential drugs and categorized lifestyle and curative drugs and really tried to set some priorities.

DR. KEMPER: With different cost sharing?

MR. McDEVITT: Yes.

DR. KEMPER: Or just no coverage at all?

MR. McDEVITT: Different tiers of -- I'm not expert on it. I've talked to some people who have been over there. But if I understand, it's different tiers of cost

sharing.

DR. KEMPER: Is there any evidence on compliance, prescriptions that are filled but aren't used and how that varies by type of prescription, type of drug?

DR. NEWHOUSE: I had some data in the Rand experiment on that and that answer seemed to be that it varied a lot by class of drug.

DR. ROWE: There are a lot of data with respect what used to be called compliance and is now called adherence -- a less derogatory term -- of patients to therapeutic regimens, particularly with respect to the use of medications and the influence of age. There was in the beginning, a feeling that older people were less adherent. It turns out, I believe -- and I may not be exactly up to date with respect to this -- that Medicare beneficiaries are no less adherent to medication regimens than younger individuals who have the same number of diseases and same number of medicines.

So the issue is the complexity of the regimen. In a 28-year-old who happens to have four medications and three or four diseases is no more likely to be more adherent than a 78-year-old. That the issue is one of complexity. But it

is a very important one. The data get to be very disturbing when you get beyond insulin, which you have to take every day or you're not going to do well, and you get to medications for hypertension and other kinds of things where there's no immediate symptom that develops if you don't take the medication. The adherence rates are relatively low and they're quite variable over time.

DR. KEMPER: Would that be related to coverage, whether it was covered or not?

DR. ROWE: I can't answer that question.

DR. WILENSKY: Why I'd like to urge the Commission to do is to try to focus today on whether the outline that's been presented and the kinds of information with the input that you've given thus far on clearly trying to get as up to date information that we can, is going in the right direction, as opposed to going through some of the particular issues in as much substantive detail because I think that we will have an opportunity to come back to do this. There are some areas that we need to cover today that we won't have an opportunity to come back to.

MR. SHEA: I do appreciate this work and I think it's certainly timely and would be of great use in future

discussion. I've got some comments on the experience in the current actively working population and employers and unions. But needless to say, a lot of people are frightened by what this is going to mean for health benefits generally for the working population.

I have a couple of suggestions. One is, I would urge you to scour around and look at the people who are actively researching this, and I'd be happy to provide you with some names for that just to see what else is out there.

Secondly, I would hope that while this focus on outpatient I think is the primary one, I also would be interest in seeing what the inpatient drug cost trends are. At least I've heard from a number of hospital administrators that it's wreaking havoc with some of their budgets and that seems to me certainly an issue that we'd want to consider.

Second, I would urge you to push a little bit more on the factors behind the costs, what's driving this, the substitution issue, is it a certain class of drugs? I've heard some analyses seems to indicate that there are certain classes of drugs, there are certain drugs within classes that really account for large amounts of the overall increase.

MS. ROSENBLATT: I thought the outline was definitely going in the right direction. I just want to emphasize a couple of things. On the benefit design, there really are a lot of very recent trends going on as you talked about, in terms of the triple copay kind of thing and I think we need to get into that. I was very pleased to see the minimizing adverse selection section in the outline.

I see there the degree of standardization in benefit design, and as I just mentioned, I really think we need to get into a discussion of what has that standardization done to the Medigap plans in terms of holding them back from what's going on elsewhere.

I also want to pick up on what Peter was asking a question about the lifestyle drugs like Viagra. I do think some of the commercial carriers have done things like used medical necessity guidelines like other conditions. I think that we all expect much more of that so I think dealing with that lifestyle drug issue and benefit design or medical necessity guidelines or some way of dealing with it would probably be a good idea.

DR. ROWE: From my point of view, the most important with respect to this has to do with

substitutability or substitution of other health care services, which you have under 2-G in your outline. I think that from a clinical point of view the issue is, if you don't cover medications for individuals out of the hospital, are they going to wind up requiring hospital services that are going to cost more for the Medicare program or for society or for the individuals? I think that several analysis that was published in the New England Journal suggested in New Hampshire that's what happened. They had a drug benefit. They couldn't afford it. They backed off, and they wound up --

DR. NEWHOUSE: They capped it.

DR. ROWE: They capped it or whatever, and their health care expenditures actually went up because of the substitution phenomena. I would think that policymakers, members of Congress and others, need to be aware of what data are available with respect to substitution. It would seem to me that's a critical issue. While you have it on your list of 20 or 30 different things here, I think that for my own benefit, to prioritize what is known about that would be very helpful to policymakers in actually making a decision about the actual cost of prescription drug benefits

if they were to be increased or decreased.

MR. McDEVITT: I've asked that question to just about just every PBM executive that I've talked to and I think it's the Holy Grail of the PBM world. Nobody can really generalize, I think. It's all very disease and drug specific about whether there's savings.

DR. WILENSKY: It's going to be a short literature review.

DR. ROWE: That's fine, but I think it's useful.

DR. BRAUN: Under the area of benefits under each type of coverage I think it's important also to consider adequacy of the coverage not just the fact that they're covered. Also I wonder whether in that listing, there probably are others but one that occurs to me is veterans, because a lot of that population are veterans.

DR. WAKEFIELD: Actually, I think that the response to Jack's question answered mine, which was just to inquire about whether or not an analysis could tease out when a drug is a substitute for another treatment and any sort of cost effectiveness of that substitution. But basically I think you answered that question.

DR. LOOP: I wonder if you could study physician

behavior, the number of prescriptions written by physicians over time. Because it's my impression that physicians are prescribing more. Maybe they're affected by the advertising demands or patient demands, but I'd like to know how physicians have reacted to new drugs and change in the mix of drugs.

DR. KEMPER: I like the outline and I guess I would urge you to look also at distributional benefits, particularly distribution of some of what coverage would mean since -- and along two dimensions. One is, for many people it's a benefit that they already have, so getting that benefit isn't really an improvement in coverage.

Secondly, it seems to me one objective is these high out-of-pocket costs as a percent of income, and you worry about low income people not getting the insulin and the critical drugs. But if you look at policy with a $500 deductible and 50 percent coinsurance and a $3,000 maximum benefit, is that really going to solve that kind of problem? So balancing that, particularly for low income beneficiaries with the benefit design to control expenditures seems to me a fundamental issue that we ought to think about.

DR. LONG: Just one little footnote. I've heard

anecdotally that a lot of Medicare beneficiaries who are also eligible for VA benefits get all their Medicare stuff except prescription drugs and then go down to the local VA. I have no way of knowing how we might do this but I would be interested if we could estimate the financial impact if they came home to Medicare if Medicare in fact included such benefits.

DR. NEWHOUSE: About 20 percent of drug spending is tied up in the retail distribution side. I think implicit in the outline is some of that, but it's not really explicit that we're going to consider how to contract on the distribution side. So I want to make sure we don't lose sight of that.

DR. WILENSKY: Any further comments?

DR. LOOP: I read a year or so ago in the Wall Street Journal that of the 10 top prescription drugs for seniors, three are anti-depressants. You might look at the mix of drugs and the most frequently prescribed just to see what that shows.

DR. WILENSKY: One final thought and then I think we've had a very good discussion on this is, the United Mineworkers health and retirement fund where I serve as a

trustee has been actively trying to do some management of the drug utilization, bringing in a gerontologist to work with some of the prescribing physicians for patients that have very large numbers of prescriptions and that appear to be at risk for adverse interaction and appropriateness and use. You might want to talk to the staff there to see if there is any of the information that as they've gone through that they would be willing to share with MedPAC in terms of how that's gone.

MR. McDEVITT: I used to be director of research there, so I'd be happy to do that.

DR. WILENSKY: Great. Thank you very much.

Scott?

DR. HARRISON: In the draft chapter on trends in the Medicare+Choice program we promised you some additional information on the changes in the Medicare+Choice benefit packages for the year 2000. My brief presentation today will present some of the staff's findings thus far and afterwards I look forward to your comments and suggestions on the chapter.

We compared the Medicare+Choice benefit offering from two points in time. The 1999 figures are from plans in

the program as of July 1, 1999, and the 2000 figures come from HCFA's Medicare Compare database from earlier this month. On the first table you've seen the top line before, it's general availability of Medicare+Choice plans to beneficiaries. In 1999, 71 percent of the beneficiaries had at least one plan in the county where they resided. At the beginning of 2000, only 69 percent of beneficiaries had a plan in their county.

The second line shows the percentage of beneficiaries that have a zero premium plan available in their county. In 1999, 61 percent of all beneficiaries had access to a zero premium plan. Note that is 61 percent of all beneficiaries, or about 85 percent of the beneficiaries that had any plan available. Currently, the share of beneficiaries with access to a zero premium plan is down to 53 percent. Thus, more than 10 percent of the beneficiaries that had access to a zero premium plan in 1999 no longer have such a plan available in their county.

We also looked at the availability of drug coverage through Medicare+Choice plans and the third line on the table indicates that in 1999 65 percent of beneficiaries had access to a Medicare+Choice that included at least some

coverage of outpatient prescription drugs, and that has gone down to 64 percent for this year. There really is a wide variation in the kinds of plans available, from unlimited coverage to plans where you actually have to pay extra for the drug coverage that amounts to the same amount as the value of the drug coverage. Perhaps you're getting the value of the drug card there; you're not getting anything else.

Then the last measure of benefit generosity we included in the table is the availability of zero premium plans that included some drug coverage. The table shows a marked drop in access to this type of plan, dropping from 54 percent in '99 to 45 percent currently.

The next slide shows the same measures of availability, this time for counties with different Medicare+Choice payment rate levels. For all measures, the plans are more available in counties with higher payment rates, as we've seen before. The availability dropoffs from 1999 to 2000 tend to be larger in the lower payment areas and for plans with zero premiums. It seems as if the plans have decided that they couldn't offer zero premium any more but they were keeping up with the drug coverage, or at least

they were keeping up offering some drug coverage.

The nine percentage point drop in the availability of zero premiums in counties with payment rates under $450 per month represents a 38 percent decrease in the number of beneficiaries with access to such plans. The decline in counties with payment rates over $550 is about 2 percent.

The next slide contrasts the availability in urban and rural areas. The very low numbers support the notion that rural area problems in attracting and retaining plans go beyond simply the fact that they tend to have lower payment rates. This year only 16 percent of beneficiaries living in rural counties have access to a Medicare+Choice plan that provides outpatient prescription drug coverage. We've discussed in other parts of the chapter why rural areas may be having trouble attracting plans.

The last slide looks at differences across payment update groups. The floor counties have low plan availability, but the erosion hasn't been that great, but you're working off a small base. Blend counties had a lot of erosion this year. The minimum update group have the highest plan availability and package generosity, and the 1999 to 2000 dropoff is modest among this group.

I should note that even though 2 percent doesn't seem like a large update, it has been large compared with the negative growth over the past two years in Medicare fee-for-service spending. At least I'm guessing that when HCFA announces preliminary updates either today or Monday we shouldn't be surprised to hear that HCFA projections, given the correction that they need to make for 1999, that all the counties are going to see updates of only 2 percent for 2001.

I look forward to any comments.

MR. SHEA: Did you go back and look at the numbers for Medicare risk plan benefits in 1998? If so, was there anything useful there.

DR. HARRISON: The data is there, but it is not clean. We will invest some time to try to get it clean. HCFA has improved the reporting each year. '99 was pretty dirty. 2000 actually looks pretty good. But '98 was still kind of...

MS. NEWPORT: I've already told Scott this but I'll say it publicly, I thought he did a fine job on the draft. I've got a few edits that, as always, I'll share with you later.

A couple things I wanted to comment on in general in terms of what the effect of some of these changes has had. Obstacles to participation. I think one of the issues with provider-sponsored organizations was misplaced or inability to look at it in terms of certain level of economies of scale. There were a lot of idealized plans out there for a while that you could start one of these and the huge up-front investment in doing that was overlooked. Also, the expectations where we could just build something around a small hospital-based provider system and keep the enrollment to something like 12,000. I actually had people say that.

I think one of the things that always the expectations, the perception and reality are quite different in some of this and what it takes to do properly, and how long it does take to grow it. I think, especially from a freestanding start.

I think that in addition to the regulatory burden which has been amplified even beyond our expectations from BBA, I think that there are efficiencies in this business that have to be driven and thought about very differently. So it's just an emphasis.

The other thing on the PPO side, I think part of the problem there on the HCFA administration of the regulations is as much the quality issues as HCFA's inability to not impose regulatory structures that work for managed care in terms of protecting the beneficiary, but just aren't needed in terms of PPOs. I think that that's a real conundrum that potential plans would face in terms of trying to do what would be a normal PPO operation. Just there's a conflict there.

So I don't know that you have to change anything in your draft, but I think just keep that as a part of maybe ongoing measurement of the effects of BBA and obstacles for getting in and offering more choice.

One thing too, the MSA application that's for 30 states, I think we just have to keep an eye on that.

DR. HARRISON: Private fee-for-service.

MS. NEWPORT: That's right, the private fee-for-service piece. I've always been intrigued by that whole idea that you would go off and spend that much more money as a beneficiary to have this private fee-for-service. So they might get their application through but I'd really like to see who signs up for that. I'm intrigued.

So again, I wouldn't suggest any changes but maybe as we go forward to take a look at how successful these are. That's it for now. I appreciate it.

MS. ROSENBLATT: Scott, as I mentioned here earlier today, I too thought this was a great paper. I do have a couple of things I want to raise and see if the other commissioners agree with me. When you talk about the PSOs I think you do a good job of saying the physicians and other providers complain about the regulatory burden but there are really other things doing it. Maybe there's not just a good connection between providers monitoring themselves.

But you never explain what those regulatory burdens are. And in particular, the biggest regulatory burden to my way of thinking has been the surplus requirement, which I think is absolutely needed, particularly -- a lot of us were talking yesterday about Harvard Pilgrim. So we may just want to add a sentence that this is regulatory burden that's needed and there have been examples of health plans getting into financial trouble.

The other thing that was kind of tone thing that I'd like to hear from other commissioners on, I think you do a real good job of talking about the balance between the

need to increase enrollment, and one of the things that managed care plans have to offer to do that are richer benefits. But as I was reading the paper I kind of get the feeling that we were blessing the richer benefits. I guess I'm a proponent of decreased benefits, and I was just a little bit concerned about the Commission sending a message very much in favor of increased benefits. So I would appreciate hearing from other commissioners on that.

Then there was just one small thing on page 16 when you talk about HMO average premium rates from '97 to '98. Again, the more recent data I think would probably lead you to higher rate increases in the commercial sector if you looked at '99 and 2000.

DR. ROWE: Do you want to qualify your general statement on the record that you're a proponent of decreased benefits?

MS. ROSENBLATT: I'm a proponent of insured benefits having adequate copays, et cetera, to adjust utilization. I do believe that increased benefits leads to increased utilization.

DR. WILENSKY: I think there was a conversation that was -- I can't remember, in one of our reports last

year that referenced a somewhat unreasonable expectation that you could continue to have the very substantial benefit difference being financed that were basically being paid the same or 5 percent less. I think that was a very useful issue that was raised before and we ought to raise it again within this context.

And at least part of what Alice may have been raising is the notion that while extra benefits may have been the draw in the past for joining a risk plan, presumably it will require, as we get better with risk adjustment, being able to provide a service that people want in the form of networks, of reduced administrative hassle, some kind of additional coordination or other best practice strategies that plans will need to develop and market, as opposed to making use of some of the extra money that has been leveraged over variations in spending around the country.

But to go in a little, I think it will require in having that discussion be understood, to talk about the variations in spending that exist around the country that get driven from the traditional Medicare; what that's meant in the past for the Medicare+Choice plans. And as we try to

get rid of some of that, what that means in the future for their being able to leverage themselves. But one of the issues that has bothered me a great deal is that we tend to focus this, in general, only in terms of being a Medicare+Choice issue, those variations, as opposed to being fundamentally a part of the Medicare program as we now know it. So it might also be useful if you would raise that.

We saw it again when Minnesota is suing the federal government because the Medicare benefits are different, and ignoring that for the 88 percent of the population who are not part of Medicare+Choice, the same argument could be made in terms of differential Medicare spending across the country. So if we get into this, I would hope you would be clear as to why this happens. It's not just a Medicare+Choice issue.

MR. SHEA: Just so the record isn't only on one side. I think we have to keep in mind, as I'm sure we do generally, that there was a trade-off here and people agreed to, when they went into a risk plan agreed to reduce choice, in some cases severely limit choices, and other of the attributes of managed care, which usually involve at least some restraint of access in mild kind of ways. You know,

the waiting times and so forth. And in some cases, much more severe problems in terms of the problems with the plans, switching and so forth. They did that for economic reasons largely, to get a better benefit package. So there was a trade-off and people were paying here to get there.

If we now go down a road of saying, that's okay but now we're going to restrict the benefits so that you're going to be paying more and more, I just think we'd have to look at that in terms of what's the fair trade-off. I'm not suggesting that there should be zero payments or any of this stuff, and I think there is some, at the low end, I would grant something to the utilization argument here. But from many years of experience of representing people of modest income who are trying to just handle the health care equation in a sensible, balanced way, it's easy to go the other way and to create just tiers of people in the health care system, some of whom have much restricted access and indeed substantial financial burden that other people could handle.

I'm just saying that there's the classic two sides to this discussion and we need to keep both in mind.

DR. LAVE: I just had a couple of observations. I

too like this chapter. I had a couple of questions which may be editorial but I think that they reflected some thought. In the introductory paragraph, the last thing it says, other policymakers wanted to see continued rapid enrollment in Medicare+Choice plans. I think there has to be a because after that. I mean, why would they, other than the two reasons that we had given before?

The reason that I thought about which we may want to put in or put out is that I think that there is a goal on some people's part to try to put in a place an infrastructure that would facilitate a change in the nature of the program. Unless you have a lot of plans out there, it's hard to make substantive changes.

So whether we want to raise that red herring, or not, but I think that we have to have a because there, because that's a different reason than more choices. It says that you want to change the structure. I think we have to come back to the realism and unrealism of what you can expect people to get with the same premium.

The other question that I have was that I wasn't terribly sure why the provisions that they're doing should not result in long term cost increases. It seemed to me

that some of the things that they were doing actually were leading to long term cost increases because if they have to keep on raising the Medicare+Choice 2 percent in order to get things in. So I wasn't terribly sure what that added, and unless there's something I wasn't picking up I don't think we necessarily want to make a comment about what the strategies are going to do.

DR. HARRISON: That sentence was referring only to the BBRA provisions. Right, the only two things there that would lead to long term increases was the change from a minus .5 to .3 in 2002, and the temporary risk adjustment, so that eventually risk adjustment gets back to where it was.

DR. LONG: At the risk of having more numbers on pieces of paper, it would be helpful to me if we could show absolute numbers as well as all the percentages that you have on your slides today. Since the bases change for each of the categories, I'd be interested in knowing, to the extent we can, the absolute number of plans, the absolute number of beneficiaries that are in these various categories and the changes from '99 to 2000.

DR. WAKEFIELD: I liked this chapter as well and I

thought that the discussion of urban versus rural contrasts were really helpful, and certainly that the case with the charts that you provided this morning. So that's really great. Thanks much for putting that together.

Two quick comments. I also wondered whether or not it might be useful, on page 24 for example, you make the statement that the panel that had testified suggests that HMOs may not be the most appropriate plan structure for less densely populated areas. No argument about that.

I was wondering if it might be, especially in light of the charts you've shown us, whether it might be worth putting in a sentence that comments on, absent managed care plans, especially absent managed care plans for the vast majority of rural Medicare beneficiaries that have a drug component, a prescription drug coverage component to them, should that encourage some additional assessment of the ability of especially low income rural Medicare beneficiaries to access supplementary coverage in addition to traditional fee-for-service?

Should we look a little bit more in that direction knowing that the same choice that exists for their urban counterparts -- that is, urban counterparts could obviously

opt to choose from Medicare+Choice plans, doesn't exist, and especially doesn't exist in light of these data related to plans with a prescription drug benefit. So maybe some comment that effect.

Another question that I have and maybe Janet can answer this actually is on page 14 there's a statement where you say that managed care organizations are in a weak bargaining position to get lower rates from rural providers. Here's my question about that. It seems to me, why would markedly lower rates be necessary to negotiate since it seems to me that we would already have providers being paid at lower rates in rural versus urban areas? In fact the real costs that could be negotiated out would be more associated with urban facilities and urban providers that tend to do more of the high end work.

I was just wondering about the tone of that, that MCOs are in a weak bargaining position to get lower rates, while those providers are already paid at fairly low rates in rural areas. So I was just wondering about the sense of that statement. But maybe you're covering something I'm not familiar with.

MS. NEWPORT: That's something I didn't catch and

I think your point is well taken. I think what it should emphasize is that in areas where -- and I don't mean this in a negative way, it's just a fact -- there are essential monopoly services and you have constraints in terms of state law and licensure requirement in terms of drive times and accessibility and availability in certain areas, providers can get paid at a higher rate on a fee-for-service basis in Medicare -- simple economics -- than what the plans are paid to cover their costs.

So this is a conflict that essentially has always been there but now it's being amplified. You used to be able to do some, basically cross-subsidization, going into more and more rural areas because we had a pretty good base. That's why the issue and the contraction and the lack of expansion in the industry right now in terms of -- we only had two expansions last year. That's all my regulatory shop used to do practically. I haven't done one in a long time.

So that issue there is the indicator of what's happening as payments are starting to flatten out and fee-for-service payments are not. So I think that maybe there is a tone correction here or emphasis that needs to be straightened out a little bit. But I think it's just some

of the areas -- I've said this before. I don't know if you were on the Commission at that point. We didn't so much exit counties as were exited by the providers.

DR. WILENSKY: Specifically, when some of the plan groups came in to talk with Murray and myself and staff at our request, what they had indicated was that the lack of competitive pressures in rural areas that you see in urban areas indeed didn't allow for any savings in terms of provider reimbursement, which is something that plans frequently can do in very competitive urban areas.

Whether or not they get paid lower or higher is beside the point. Relative to what Medicare is spending, can the plans get any better pricing? And the answer was, because there was so few in them in rural areas they basically couldn't. Furthermore, since the reporting requirements were an added burden that providers had to deal with, it didn't provide much incentive for them to join the plans. So that was indeed what we heard.

MS. NEWPORT: I've been a longstanding critic of the notion that the industry itself put forward for many years that we should be everywhere. I just never thought that that was a realistic assumption. We sort of got

foisted on our own petard, if you will, on that. So I think that it just doesn't make sense at a certain point. It doesn't work. You've got to partner with providers, and it's not a good partnership automatically.

DR. WAKEFIELD: I'd just add, I think that that was the tone that we got from the rural expert panel who testified before this commission, that this isn't necessarily the way to go on all rural, sparsely populated areas. If not that, then again using the example of prescription drugs that I was speaking to initially, then what? So if that's not reasonable, which it would certainly would seem to be that it is not reasonable to have accessible in all areas, then what? Which is what prompted my first point to you.

DR. KEMPER: I just had a comment on the paragraph at the top of page 16, the second half of the paragraph. There are a couple of comments in there which I wasn't sure we necessarily wanted to make. One is that efficiency gains from managed care have already been achieved. I'm not sure we're at the point to really know that that's the case. In fact one would hope that we're launching a change that would have additional long run benefits for cost as well as

quality.

You also talk about profitability and the effects of the underwriting cycle on profitability, which I don't -- but I wonder whether our payment policy ought to be driven by the underwriting cycle in the commercial sector. So one way to treat this would be a more general statement about payment versus additional benefits, because I just think that paragraph needs a little work.

DR. WILENSKY: Any other comments?

MS. NEWPORT: Just one note. In your references in the BBRA to allowing institutionalized folks to not be locked in after 2002 when there's going to be a lock-in in enrollment periods, I think that we need to keep an eye on what I would see as probably a series of efforts to create exceptions to the closed enrollment piece. I think it's going to become a more important issue in terms of stabilizing the industry as well.

Again, I don't think you have to change this but I think the Commission needs to take a look at that issue. It's a lot broader than it first appears and has a lot to do with beneficiary access and protections, and I think it's something that we have to be careful of as we go forward.

DR. WILENSKY: Scott, let me try to amplify a little bit a point Mary raised with regard to this issue that perhaps we don't have quite the right choice set available yet. I would see this chapter, going back to some of the issues that we raised in the past about trying to open up choices for seniors, making sure that we don't have forces in there that basically lead to unstable results because of the design of these. That gets to some of these variation in pricing and expenditure issues that I had mentioned earlier, and some of the difficult issues that now exist because of the way statutorily these are defined.

It would also provide an opportunity to raise the fact that whatever is going to work in rural areas, if we want to allow choices, the pretty rigid structure of what kind of plans can exist isn't likely to do it. It doesn't appear that that's going to happen. And to talk more -- we can at least talk about some of the other models that have been raised, that our rural panel raised that might be more appropriate for a rural setting that doesn't quite fit the rigid, regulatory model of a risk plan in Medicare+Choice. To just give it a little bit of balance.

To the extent that we have too many goals being

placed on this one program, I think that one of the fundamental questions is, do you want to have a stable plan and set of choices that people can choose from, or are you trying to do this to drive savings in the program? That fundamentally takes you off into directions. And that we have had too many objectives in this one program and consequently not seeming to be very happy with what we're changing, and clearly not achieving some of the goals. I think that's a part of what you've heard this morning.

DR. ROWE: Scott, I just had a couple comments on the figures, to get back to yesterday's theme of the cartoons. Because there's a dissonance here between reading the chapter and hearing the discussion about some of the pull-back, if you will, in the marketplace and then looking at these figures.

With respect to enrollment, I'm referring to this page that says M+C chapter chart one. You have two figures on that page. With respect to enrollment, I think we have a floating baseline here. That the total number of Medicare beneficiaries has changed and it sort of suggests it's stable here. We should have a percent penetration or something that like that would be a more fair representation

of what's happening.

With respect to growth in enrollment, obviously that is a direct function of penetration. For instance, if you were up to 98 percent and you got to 100, your growth in enrollment would only be 2 percent. It would be a very low number on this chart and it would look like you were doing poorly. So actually what you want to represent I think is the percent of the available market which is penetrated, how much market share that you don't have are you taking, as opposed to your growth in enrollment which is a kind of diminishing returns kind of figure.

I mean, if you look at this you say, why is enrollment going up and growth in enrollment going down, and how can this be? So I think that if you made those modest adjustments it would be more concordant with the text.

DR. WILENSKY: Thank you very much. Do you feel like you have enough guidance?

DR. HARRISON: Yes.

DR. WILENSKY: We're going to do now the beneficiary access to quality health care that we postponed yesterday. Beth?

MS. DOCTEUR: Housekeeping first. The draft

chapter on beneficiaries' access to quality care can be found behind Tab E in your binders. Like Chapter 4, this chapter also has a plethora of authors, half of whom are up here at the table and others are in the audience in case you have specific questions that they can be helpful with.

Let me say that Janet and I were going to be sharing this presentation. I was going to be some of the overview and talking us through the recommendation, and Janet was going to be presenting the findings from the analysis of the Medicare current beneficiary survey. Janet's been stricken by laryngitis so she's going to be here to croak out some answers to questions if necessary, but I'll be your presenter for today.

For the benefit of the audience, the topics that are covered in the chapter focus on describing the BBA and the BBRA changes that we have think have the greatest potential implications for access, and summarizing the studies of the effects of those changes where we have studies conducted either by MedPAC or studies that others have done that have looked at the extent to which those changes, particularly the BBA changes, have affected beneficiaries' access to care.

We also have an analysis from the 1997 and 1998 Medicare current beneficiary survey that looks at various measures of access to care and satisfaction with care among beneficiaries. We also have an analysis of trends in beneficiary financial liability that Dan presented to you last month and he has made some revisions to that analysis that is included in the chapter.

Let me summarize the findings from the 1998 Medicare current beneficiary survey analysis that appeared in the draft chapter. We compared the characteristics of beneficiaries who were in the traditional program and Medicare+Choice just to give a sense of how the populations vary which can help in interpreting some of the finding later on in the chapter. As we found in the past, we found that rural residents, disabled beneficiaries, and those in poorer health are more likely to be enrolled in the traditional program versus Medicare+Choice.

We also found, again as we have in past analyses, that beneficiaries who are African-American, in poorer health, functionally impaired, disabled, of low income, or lacking supplemental insurance continue to be more likely than others to experience access problems in the traditional

Medicare program.

Now going on to some of our comparisons of access between 1997 and '98 let me make a couple of general statements before going through the findings. As you know we had hoped to bring you this analysis in December and we were unable to do so because we were not able to get the data until the end of December. We've included the tables in the report and we are confident in the estimates that are presented to you. I'm sure some commissioners noticed that the tables comparing '97 to '98 doesn't show which changes are statistically significant.

We have run some statistical tests on these numbers at this point and we're reporting to you those preliminary findings based on those tests. However, I would urge caution. There is a possibility that some of these determinations will change. We need to revisit the tests. The survey sample if very complicated and it involves a longitudinal survey where some of the survey respondents are the same respondents in '97 and '98. There's also some cluster sampling issues.

The short answer is that we're confident in the estimates and any changes that were found are very small.

However, which ones are significant is still subject to change. You'll see another iteration of this so you can see which changes have come about. So with that caveat, let me go through the findings very quickly.

Looking at the access and satisfaction in traditional Medicare from '97 to '98, we did find a small decrease in reported delays due to cost. We also found a small increase in the percentage with no office visit from '97 to '98. We didn't see a change in access by other measures, and we didn't see changes in satisfaction rates.

Looking again at the Medicare managed care side of things, looking from '97 to '98 we saw a small increase in the percentage of those who said they delayed care during the past year due to cost. We didn't see changes in other access measures nor satisfaction rates. Fewer beneficiaries said that the reason they joined their plan was because of lower cost, and more said that they did so because of better benefits. We did see a small increase in coverage of most benefit categories. Keep in mind this is a survey asking beneficiaries, did you have coverage X benefits? So this isn't something that's derived from HCFA data of the benefits like Scott's analysis that you just saw previously.

The draft chapter conclusions for your discussion are first that we don't see evidence at this point that the Balanced Budget Act changes have posed a significant threat to beneficiaries' ability to obtain needed medical care. This is the overarching conclusion based on the studies that we reviewed in the chapter. But we also go on to say that where we did some findings of potential problems, they warrant further examination.

To review some of the findings that we highlighted for potential further study or monitoring include our finding that the percentage of Medicare beneficiaries who lack supplemental insurance coverage has increased consistently from '96 to '97 to '98. And several of our findings in this study that show that these beneficiaries have higher rates of access problems than others is something to keep in mind.

Also, another example of a finding that we've highlighted is findings from studies by other groups that have shown that there potentially are problems with access to skilled nursing facility care for beneficiaries who are more medically complex. We note that there are changes in the BBRA that could affect those and it's something to keep

an eye on in the future.

The final conclusion then is that continued vigilance is still needed due to the nature and scope that are still underway. We've noted in the chapter that a lot of things that the Commission has highlighted for attention haven't actually been implemented yet.

So that brings us then to the draft recommendations in this chapter. This draft recommendation reflects first the fact that the congressional mandate that the Secretary monitor and report annually to the Congress on access to care has now expired. As we note in the chapter, this mandate was inspired, motivated by the move to the physician fee schedule which has now been fully phased in.

We try to make the case in the chapter that some of the changes that are underway now as a result of the BBA are equally significant in terms of potential effects on access to care. And therefore suggest to you this draft recommendation that the Secretary should periodically identify potential problems in beneficiaries' access to care, and should do studies to determine whether in fact those potential problems have arise, and to report annually to the Congress on the findings.

DR. WILENSKY: Would you like us to take up the specific recommendation at this point?

MS. DOCTEUR: Yes.

DR. WILENSKY: Any comments? Any reason not to proceed forward?

MS. ROSENBLATT: I support the recommendation but have a couple of comments on the chapter.

DR. WILENSKY: We'll do that in a second. Are we all comfortable with regard to the recommendation?

Okay, why don't you go ahead.

MS. ROSENBLATT: These might be editorial, but some of them may not be considered editorial. On page 25 there is a comment taken from a PPRC study in 1997 that says, in general Medigap policies offer fewer benefits at a higher cost than other forms of supplemental insurance or managed care plans. My guess is if it was in a report from 1997 it's based on pretty old data and I'm not sure that would still be as true a statement as it was back then.

I have a similar comment on page 28 at the top. Again, individuals purchasing Medigap reported having higher premiums, higher out-of-pocket costs. While I think Dan's study shows that that's true, again I'm just concerned about

does this match with recent data.

Then on page 29, the middle paragraph, in general, beneficiaries with employer-sponsored plans have lower premium costs than those in Medigap plans. Is that because of the employer cost sharing or is it really a true lower premium cost plan?

MR. SHEA: Just on this point. I thought that the evidence was pretty strong and something which we talked about earlier that the Medigap coverage is not a great deal. What happens in employer coverage is that the employer provides some package of benefits with much smaller cost sharing. So as an economic equation it's a better deal for the beneficiary. Maybe I'm missing your point.

MS. ROSENBLATT: My point is, it's a better deal for the beneficiary because of the employer cost sharing. Whereas the sentence here makes it sound like it's just a better deal whether or not there was employer cost sharing, and that was my point, Gerry.

DR. NEWHOUSE: But we know that the individual Medigap has much higher loading because it has to be marketed individually. So in that sense it's a better -- that hasn't changed and that would seem to be a dominant

factor.

MS. DOCTEUR: If I could just clarify, one of the comments you pointed to was the sentence on the top of page 28, individuals purchasing Medigap reported having higher premiums, higher out-of-pocket costs, and fewer benefits than they had previously in their managed care plan. That actually is very recent data. That is from the Lashover '99 study of folks who lost their managed care coverage. So that one at least is still about as current as...

DR. KEMPER: I have a number of comments on the chapter which I can give you separately. I wanted to focus on the summary statement up front because it seems to me in this chapter that summary paragraph is as important as a recommendation would be in a different chapter. There are two comments I have.

One is with respect to the balanced budget changes, BBA changes, which I think is what you focus on now, it's kind of a mixed message. It struck me that the first bullet that you had that there are really no access problems is overstating what you found. That there's no strong evidence of pervasive access problems might be the case, but that there are indications in studies of others of

areas where there might be problems that warrant further monitoring.

So the second two bullets that you had on that slide seemed to make sense to me, but the first one undercuts them in the generality. So that's one comment.

The other is that it seems to me that summary paragraph ought to reiterate findings from the past that haven't changed. So that we found, as before, that there's differential access for vulnerable populations, persistence of catastrophic costs. Actually, I guess that's a new finding. But in any case, having nothing to do with BBA.

I guess I thought that the decrease in the percent of people with supplemental coverage was something that ought to make it to that summary paragraph because you did demonstrate that they seemed to have poorer access. So the general monitoring findings, even if they're just the same as it's been in previous years about differential access, it would be worth reiterating that.

I'd be interested if others agree with that, but that message it seems to me is something we all ought to -- whatever it is, we all ought to agree on.

DR. WILENSKY: Let me just ask you something

following that specific issue. My recollection of previous findings, to the extent that we reiterate previous findings, is that what Medicare has shown is that except in areas that were so-called hot spot areas where the problem appeared to be lack of health care personnel and health facility availability, there has not been any systematic access problem that has been observable in Medicare. That's sort of statement one.

Then statement two, vulnerable populations have historically or traditionally had somewhat more difficulty. But again, the blanket statement that at least has been made, to the extent that we reiterate blanket statement, is that there does not -- it doesn't seem quite as strong a statement as you may -- no strong evidence is that the general look is that there doesn't appear to be systematic access problems in Medicare.

That what exists seems to be related to the fact that there's a problem in the area; it's not a Medicare problem. Which of course, I would say about the same with regard to the catastrophic is that that's a clear design problem as opposed to a Medicare access problem. It's like saying Medicaid doesn't cover all of the poor.

DR. KEMPER: Right, although this chapter covers both. So I guess if you'd say what out of the findings of the chapter ought to be pulled out and highlighted, it seems to me that's one of them.

I agree with your first comment that sort of broad brush real access problems --

DR. WILENSKY: That's what it was. But I don't disagree with you --

DR. KEMPER: That might be a way of dealing with my first comment, that that overarching statement undercuts the BBA. The BBA could be treated sort of as hot spots or major program changes with some cautionary findings of others.

DR. LAVE: I wanted to really reinforce what Peter said, and that has to do with what do we infer from the access to home health agencies and SNFs from the data that are presented in here? First of all I would say that the report is not entirely consistent with that. Sometimes we don't find anything. Sometimes we find suggestions. Sometimes we find more.

I guess as I read this I was coming out more where

Peter is, that it looked to me as if there was the likelihood of serious problems coming up. So the general conclusion I think would not raise the level of concern that I felt when I read the report. That's sort of reading and listening to people. Now it is clear that people eventually seem to find something, but we don't really know what happened between the tried to place and the eventual -- so I just suggest that you look at that.

The second thing that I have, and this is just a terminology thing. I would say that the prospective payment system for SNFs has actually been implemented. They are being fully prospectively. What's being phased in is the national rates. There is a difference I think between those two concepts because they are being paid fully prospectively. It's the national rates that are being phased in.

DR. BRAUN: I wanted to come back to Alice's retiree employment insurance and Medigap. I don't know if that has changed. I do know that more retirees are now in HMOs and they're fairly well covered. But I know that in the past the problem was that employer retiree coverage was frequently duplicating Medicare and really the only

advantage -- so they had the same coinsurance responsibilities they would have with Medicare or actually were using Medicare. The only thing was the prescription drugs, which was a great benefit. And I know a good many people carry both Medigap to cover the coinsurance situation and also their employers in order to cover their prescription drugs. But I don't know if that's still the situation or not.

MS. ROSENBLATT: Thanks, Bea.

DR. NEWHOUSE: I'm wondering if it isn't worthwhile putting into the summary an explicit statement about that no study has addressed the SNF issue, particularly if we retain a flavor of broad brush things are okay, since that was a major change in the BBA? We do address it here. I mean, there is reason to believe that there might be a problem there, or a greater reason to believe that there might be a problem then in the rest of the area except home health perhaps.

And we may want to say something about home health. I just think it's harder to define appropriate access there, as we've said, so I'm not sure I would want to pull that into the summary. But some explicit statement

about SNF and perhaps home health I think should be in the summary.

DR. WILENSKY: I was trying to look through the chapter to see -- I know the discussion that indicated a decline in Medigap coverage. I wasn't able to quickly find whether the Medicare-only population has changed over this period. If that was in there, could you share that with me?

MS. DOCTEUR: We don't have it in the chapter and I don't remember the numbers offhand but we can absolutely add that.

DR. WILENSKY: It strikes me that it's not the same but it's a different way of looking at this issue, because that's really the most vulnerable.

DR. ZABINSKI: My recollection of the numbers is that the percent went up from 12.2 percent to 14.4 percent from '96 to '98.

DR. WILENSKY: The other thing that would be of interest to me when you look at that is whether the Medicare-only are inclusive or exclusive of the QMB, SLIMB populations. Again, just because it's a clearer statement about the kind of vulnerabilities that Medicare-only without the supplemental programs, that these individuals face. So

it's just another way of looking at the vulnerability outside of the actual use or out-of-pocket expenditure.

MR. SHEA: My compliments on a good draft here. I thought it was a difficult task and done generally very well. I would associate myself with the comment by Peter and Judy earlier about I had some of the same reactions to some of the characterizations. I think maybe they need a little bit more oomph to them on the concern side.

A specific thing that struck me was that on page 2, the last sentence in the run-over paragraph. I don't think that the conclusion in that sentence really comports with our discussion earlier about the prescription drug cost. I certainly think there's enough evidence on the table in regard to prescription drug costs and the increase to raise a significant concern. Yet we say, it did not provide cause for concern in the near future.

I think in some areas there are clearly reasons to be concerned about what the next year or the next couple years is going to bring.

DR. WILENSKY: Any further comments?

I hope that that flavor comes through. Certainly the purpose of having the recommendation that we're doing is

that wherever we are now, there is reason to be vigilant in the future, more so than in other years because of all of the changes that are going on and where we don't really have data yet to explain. I would think the home health and both SNF are probably the most obvious areas of concern because of the size of the change in payment that's occurred and at least the potential for access that that suggests.

MS. RAPHAEL: Just one minor point. The studies have to do to with post-acute often rely on discharge planners as the proxy to determine whether or not there is access. I think that's certainly an important element, but people come in from the community, not only from hospitals.

Then I think the secondary question is, if you get through the gate, do you get the amount of service that you need? I know that's very hard to calculate but I think it is an important issue.

MS. DOCTEUR: The latter part of the study is actually what we're hoping to address in the external research contract that we're putting out.

DR. WILENSKY: Thank you. Good chapter. Appreciate the efforts that have gone into this.

We are going to have public comment and then we're

going to review the revised recommendations from yesterday. Then if we have the time we're going to start the inpatient data section.

DR. ROWE: When do you think we're going to be finished today?

DR. WILENSKY: Definitely no later than what we're scheduled; perhaps earlier. My presumption, in the interest of the commissioners is, if we have the time we ought to start the afternoon session in the morning.

MS. WILLIAMS: Deborah Williams, American Hospital Association. I wanted to comment on an item from yesterday and that's whether the revised APR-DRGs would change the administrative cost from hospitals. It's my impression that when you look at it from both the outgoing side when a bill leaves a hospital that there is no additional administrative because it's based on diagnoses, correct? And that's what goes on the bill to HCFA.

The other area that it could affect is where the bill comes back from HCFA where the reconciliation clerk has to run a grouper and compare the DRG from that grouper to what HCFA says it got paid. Now if in some way the APR-DRGs were less certain than the current DRGs that would be a

problem. However, if I suggest that running different groupers gets you different answers, it's more of a problem there than administrative cost.

So it doesn't look from the hospital point of view that there are many costs except perhaps for training for the finance people, one-time costs to understand the new system.

The second thing I wanted to comment on was the area of coding problems in the outpatient setting and how they relate or don't relate to what the expenditures are. There is an issue, as you know, of the undercoding of the level of medical visits. But an end-up inspection of the whole problem shows that there are other offsetting factors.

For instance, one-third of the outpatient PPS data did not group. If in that ungrouped data there are a higher proportion of medical visits, which is likely, that means actually the conversion factor is understated and projected expenditures are overstated. The reason behind that, which is probably not very good for public comment, but the reason behind that is that there are different levels of payment in the current payment system with medical visits being paid at a higher level relative to cost than other services.

My point being here is that it's hard to tell what the projected level of expenditures will be, whether HCFA is overestimating or underestimating.

DR. NEWHOUSE: Deborah, if the conversion factor is too low, how are expenditures too high?

MS. WILLIAMS: In other words, the projecting --

DR. NEWHOUSE: I thought I heard you say that we had underestimated the conversion factor, which I followed. But then you said that led to an overestimate of spending.

MS. WILLIAMS: I'm sorry, it's the opposite. Yes, you're right, total expenditures would be too low. Relative to the first problem, the undercoding of medical visits leads you to a too high conversion factor and projected expenditures that are too high. The missing medical visits; that is, one-third, for example, of emergency revenue centers are uncoded, leads you to a conversion factor that's too low and projected expenditures that are too low.

DR. WILENSKY: Thank you. Any other comments?

Kevin, can you review the E&M recommendations, or any other recommendations we have?

DR. WEINRAUCH: This is the revised first draft recommendation for E&M guidelines. HCFA should continue to

work with the medical community in developing E&M guidelines, minimizing their complexity, and exploring alternative approaches to promote accurate coding of E&M services. The underlined portion is what we added.

DR. WILENSKY: Is there any comment on the E&M coding?

Fine. Continue on the second.

DR. HAYES: The next recommendation is in response to your discussion yesterday about the concern that separate expenditure targets for physician services and OPDs and ASCs was probably not a good idea since it would contribute to inconsistency in payment updates for services provided in the three settings, physician's offices, OPDs, and ASCs. So what we have here is a draft recommendation and then in the handout that I circulated there's some associated text that would go with that recommendation. All of this would appear in the section of the chapter on expenditure targets.

DR. NEWHOUSE: Kevin, my question here is in the second sentence on, the Secretary should not implement. Is this there because we think that the Secretary has the authority or thinks she has the authority to implement even if the Congress does not enact?

DR. HAYES: That's right. The way the BBA is written and the way it describes how payment updates will be accomplished for hospital outpatient departments, it's possible that the Secretary could implement an OPD-specific sustainable growth rate type mechanism. In fact in the draft proposed rule that HCFA put out in September of '98 that's what they laid out as an option for implementing their so-called volume control mechanism.

DR. NEWHOUSE: I think we should probably maybe take three sentences rather than two then, because the juxtaposition of this phrase, the Congress should not enact and the Secretary should not implement, is very odd.

DR. ROWE: Perhaps better syntax would be, the Congress should not enact nor should the Secretary implement.

DR. NEWHOUSE: But I don't like that for the same reason.

DR. ROWE: At least it would be English.

DR. NEWHOUSE: I understand. No, I agree with you syntactually but it didn't go to my substantive point. I think we need to make clear that we're writing this on the supposition that whether the Secretary has authority is

ambiguous. Therefore we are writing this both to the Congress and to the Secretary. At least that's what I understand to be --

DR. ROWE: Why don't you just say that setting specific expenditure targets for these settings are not appropriate? [Inaudible.]

DR. NEWHOUSE: Fine.

DR. WILENSKY: I agree, I think that's -- and then we have to deal with it as to whether it's statutory.

DR. HAYES: One minor clarification. We try to phrase our recommendation in what you might think of as an active voice where we're trying to be directing someone. So in this case could we say that the Congress and the Secretary should avoid setting service --

DR. WILENSKY: Yes.

DR. NEWHOUSE: Yes.

DR. ROWE: No, you should say what you want to say, Kevin.

DR. WILENSKY: I htink the point is usually we do want to be clear as to whether we're directing this to the Congress or to the Secretary. I guess the only other way is to indicate a lead-in phrase that it's unclear whether this

is an issue of statutory --

DR. ROWE: All you have to do is say that setting specific expenditure targets should not be developed or implemented.

DR. WILENSKY: I don't know whether you can think about a way to try to capture both our usual distinction that we are directing this both to the Secretary and to the Congress that separate expenditure targets not be implemented.

DR. LAVE: My concern is with the first sentence of this. I'm not sure that it adds anything and I don't think this recommendation has anything to do with consistency. So I don't know why we just don't eliminate that. Because when we were talking about consistency and worrying about updates, we were sort of worrying about did we want to go to a per-unit or whatever. In this one, if you say we want to have consistency of payment updates, it strikes me that expenditure targets are consistent.

So my recommendation would be that we eliminate the first paragraph and basically that the argument should be that the silo is a significant problem. There is too much shifting and we do not recommend -- we direct or

whatever it is that we do.

DR. NEWHOUSE: But I think that's why the first sentence is there. The concern was if you had separate silos with expenditure targets that you would potentially get quite inconsistent updates if service shifted from one silo to the other.

DR. LAVE: That's the way I read that thought.

DR. NEWHOUSE: But then it's a problem with the way it's worded I think.

DR. LAVE: When I read consistency I would say setting an expenditure target would be consistent. I would not see the consistency as having to do with having an outcome that I don't like. So maybe that's just my problem, but I think that having that first sentence there with these many interpretations of consistency may be a red herring and what we --

DR. NEWHOUSE: How about similarity instead of consistency then?

DR. LAVE: But I don't even know where the similarity comes from. I don't see what that adds, Joe. Maybe it is only me. Maybe it is only I, and it may be an obviosity that I'm overlooking. But I don't understand in

the context of this recommendation what consistency has to do with it.

DR. KEMPER: Maybe it is only I and thy. But I don't disagree with the second statement here, but there's an easy conclusion that you come to from this recommendation is, then let's have a global expenditure cap cutting across all the silos. If there were a recommendation to that effect that, neither should the Congress or the Secretary implement a global expenditure cap across all the sectors, then I would be very comfortable with it.

DR. WILENSKY: We have not ever had that discussion.

DR. KEMPER: I thought we've had it quite a lot.

DR. WILENSKY: Not really in terms of a global expenditure. You meant ambulatory. You just mean ambulatory.

DR. KEMPER: I'm sorry, across the ambulatory, outpatient.

DR. WILENSKY: That is not what you were saying.

DR. KEMPER: Yes, we have not had that discussion.

So to me, it would be an easy step from this recommendation to an expenditure cap across all the

ambulatory services, and I think the thrust of our discussion was quite the contrary, that we would prefer to have updates. If that were the alternative, we'd prefer to have updates. So I don't know if that's the thrust of your comment, but that's my concern about this.

DR. WILENSKY: I can't remember now the other recommendation. No, I agree, to the extent we don't have another recommendation elsewhere in the chapter, that we ought to have a two-part recommendation. We don't recommend setting specific ambulatory care expenditure targets. We also do not recommend the use of a global ambulatory care expenditure target, at least at the present time. When you have the discussion in the chapter -- I know you have the discussion in the chapter about all the difficulties. I think that as of this time we would not recommend doing that, and we don't recommend the site-specific.

DR. KEMPER: That would certainly respond to my concern.

DR. LAVE: I think that the site-specific stuff, I think we all agree, never. And I think at this time, give wiggle room for people who haven't really thought the whole thing through.

DR. WILENSKY: Right, about whether we'd ever have the data to allow us to do that. We may be able to just do a relatively clean recommendation on those two. That we don't recommend the first, we don't recommend the second at this time.

DR. HAYES: So one way to do this then would be to have -- I was almost going to say that we do not want to have -- we almost have one recommendation which says we do not recommend either setting specific expenditure targets or a global expenditure target for all three settings.

DR. WILENSKY: For all ambulatory care, yes. I think I would accept that.

DR. ROWE: I think the problem you're getting into, Kevin, with respect to how to couch this is that while you would like to use the active voice, as opposed to most recommendations this is a non-recommendation. We are not recommending that something be done. We're trying to prevent things from being done. And there are two things that we want, two polar extremes that we want to avoid here, and that's what we're trying to do.

DR. WILENSKY: I think if you do it as you just phrased it, that is responsive to the commissioners.

DR. KEMPER: But I would say recommend not. Not, not recommend. We are basically recommending that they not --

[Laughter.]

DR. WILENSKY: I understand. We are recommending not doing it.

DR. ROWE: This is a prohibition.

DR. ROSS: Now that everyone's reached a consensus, let me propose a couple of changes. One is we really should be talking about rates here rather than updates in the initial motivation. Something along the lines of, to promote consistency of payment rates among ambulatory settings, et cetera.

DR. LAVE: I think we don't want the consistency in there at all, because our whole --

DR. WILENSKY: It's not relevant.

DR. LAVE: It's not relevant is what I would --

DR. WILENSKY: The recommendation is clear and stands on its own without that phrase. We're saying not to implement, recommends not implementing either site-specific or a global ambulatory care expenditure target. Then the text is very clear about the rationale of what we both want

to do and don't want to do.

DR. HAYES: So we would just not have this first sentence in the recommendation at all?

DR. WILENSKY: Yes, I think that is where we came out, because I think the discussion indicates our concerns about consistency.

Further comment? Thank you.

We're going to do the revised ESRD after lunch to make sure we captured the flavor. The one thing I wanted to get a sense from commissioners before we have the discussion, I think we were pretty clear about trying to be more directive of having HCFA use its data to set a risk adjustment so that ESRD patients would be given the opportunity to join managed care plans.

What came up at the very end that I wanted to sort of informally poll the commissioners' views is whether we wanted to put a date specific or whether we simply wanted to say, as soon as possible. The date specific that had been raised at the end of the discussion was by the end of fiscal year 2001, which would give a year and-three-quarters. I don't know whether we can wait and see what happens, or we can provide a date. But we haven't spoken with HCFA. You

either can mull it over and be prepared to respond after lunch when we have this discussion or --

The only reason that it came up was because the general concern here was -- the reason we wanted to have this motivating recommendation was the concern that otherwise HCFA will do it when it gets to it and it will be not any time soon. While taking away the evaluation of the demonstration as a prior requirement will at least take away one excuse, it wasn't clear whether it would really provide the motivation that sounded like you wanted to have present. So if you'd like to you can think about it over lunch.

DR. LAVE: I want to raise another thing about that recommendation. This is something that we talked about after the discussion from the floor. That is whether or not in fact we ought to encourage HCFA to oversample the ESRD beneficiaries in terms of their satisfaction with care, so we would have the information to know whether there were problems. So we'd have to make a recommendation to direct them to do that since we would have then patient satisfaction, risk adjustment, and some outcome variables when the time came.

DR. WILENSKY: Nancy, did you just hear the second

piece of what Judy suggested?

MS. RAY: Yes, I did.

DR. WILENSKY: Okay, post-acute quality. We'll see whether we can maybe make contact with HCFA to see whether there's an issue.

MS. DOCTEUR: Revised draft recommendations two and four from the post-acute quality monitoring that you discussed yesterday. The first revision is to draft recommendation two to the first bullet. The change is trying to clarify what it is that you've said you wanted to do in terms of better coordinating post-acute care quality monitoring systems. I think what it's trying to do is to specify, if you think about the way in which you'd want to go about coordinating quality monitoring systems compared with what they are now.

You could think about doing it in two different ways. The first way would be to create a one-size-fits-all sort of system where you would try to monitor the same things in all the post-acute care settings. This is specifying that you want to do it the other way, which would be to acknowledge what is unique about the individual settings and to measure what's important, the core important

measures that you've talked about in the past. So this is really a wording change to try to get at the concerns that were raised yesterday about this being stating the obvious.

DR. WILENSKY: Are people comfortable with this? Any comment?

Thank you.

MS. DOCTEUR: Draft recommendation four has been changed also to try to strengthen the language in response to commissioners concerns yesterday. The changes are wording changes up front in the early statement to be much more direct and to say, the Secretary should rationalize the collection of patient assessment data, as opposed to saying she should take steps to do so, and just try to be more direct about what it is we want her to do.

Similarly, the first bullet is changed to be very specific about what we're talking about here is limiting data collection.

And the final bullet on the next page down has also changed to again emphasize that what you mean to do is to reduce the reliance on patient assessment data, not to say that the Secretary should do more to collect different types of data.

Are these consistent with the changes that you wanted yesterday?

DR. ROWE: That's at the end?

MS. DOCTEUR: The very end, the very last bullet, adding the phrase, to reduce reliance on patient assessment data. I think one of the concerns from yesterday was the sense that there -- trying to do more. And this is specifying, no, we're saying, do something different. Do those address your concerns?

DR. WILENSKY: Any comment that anyone wants to make?

Okay, the answer is yes.

DR. LOOP: The problem is it's still, for me, a little wordy. I'd rather see some of that in the text and have a shorter recommendation, which I'll be glad to provide to you sometime. But the people who write these forms will say that the data collection is correct the way it is right now. And the fact of the matter is it really is --

DR. WILENSKY: Excessive.

DR. LOOP: Beyond excessive.

DR. WILENSKY: I think maybe if the commissioners are willing, why don't we have Floyd in fact do another

version, circulate it. I think we understand the issue that's been raised. It will either have an acceptance in its altered version or we're going to go here, understanding it's wordy.

DR. ROWE: I would suggest is the word limiting gives them the option to do what Floyd just suggested they might do. Whereas if we use the word reducing we're sending the message that we think maybe it's too much. So if we say, reducing data collection, as opposed to limiting, we're sending the message that we think there has to be less than there is now as opposed to what you have now is justifiable.

DR. NEWHOUSE: Beth, can you or maybe someone on the Commission remind me of what sampling, if any, is contemplated with this data collection. Are we talking about 100 percent samples?

MS. DOCTEUR: Remember that these patient assessment data that are being collected are used both for payment and for quality monitoring purposes. So given that they have to collect it for 100 percent.

DR. WILENSKY: It's not really clear that they have to. I mean, you can do quality monitoring --

MS. DOCTEUR: Certainly for the quality monitoring

side. It's just for payment.

DR. NEWHOUSE: Then I'm not clear what we're talking about in terms of reducing. If we have to collect it for payment --

MS. DOCTEUR: It's the items. For example, the MDS has 300-odd items and a subset of those are used for payment and a subset are used for quality measurement. Although remember, in the MDS case we're not even clear that the MDS provides useful information for monitoring quality on the Medicare side. Only on the Medicaid side perhaps.

DR. NEWHOUSE: I understand. Let me go back to the generic point. For the stuff that is not used for payment then, why can't we be talking about sampling?

MS. DOCTEUR: There's a paragraph I think that could be expanded in the chapter that mentions that that's one way to go to try to break it down, to do sampling.

DR. NEWHOUSE: To reduce the burden?

MS. DOCTEUR: Yes, for the quality monitoring.

DR. NEWHOUSE: Maybe you could have a phrase something, including the use of sampling, in the recommendation.

MR. SHEA: I'd support the notion that Jack raises

of conveying a sense that we want some of this cut out, particularly in the number of items sense. I'm not totally comfortable though with simply substituting reducing for limiting because then I think the phrase reads as if what is now collected is the universe times 10. That is, it's the right data and the wrong data, and we want to reduce that.

I don't think we are prepared to say, I wouldn't be prepared to say that they're collecting the correct data. So it's not a matter of taking what they have and simply shrinking it back. It's a matter of getting the right data, the right quality measures put in. So I don't know where you go with that phrasing-wise, but it seems like it could get worked out.

DR. WILENSKY: I think there were two. One is the right data, and the least data needed for the two purposes of payment and quality monitoring, including sampling. I think the sense has been that the data collection is more than is needed to do quality monitoring and to do payment and that that's really what the complaint is. Is that you could have a more parsimonious data collection effort, which would reduce burdens both to the providers and therefore make more care available to the patients, and that that's

not being done.

MR. SHEA: That's why I thought limiting actually was a good word in that sense. Maybe if we left that and then added something about, by this we mean not only striving to get better measures but reducing the amount of the total.

DR. LAVE: That would be in the text.

DR. WILENSKY: You can look at this again. I'd encourage, Floyd, if you want to give a crack at trying to restate this so it is stronger and circulating it. We have agreed that we will try not to make changes following the meetings. I think though this is strictly a wording change to capture the sense that I believe we all agree on. So if we can get an easy comfort level with the revised wording we'll do it. Otherwise we'll go with what we have and just try to make sure the text makes clear...

MS. ROSENBLATT: Gail, can I just make one suggestion? What about just that first sentence, a period after post-acute care providers. Rationalize picks up everything we're talking about -- and move everything else to the text.

DR. KEMPER: How about limit and rationalize, and

then put all the bullets in the text?

DR. WILENSKY: Do you have a sense or would you like to think about it?

DR. LOOP: Review, limit, and rationalize, because they really have to redo the whole form.

DR. NEWHOUSE: That's talking about years now.

DR. WILENSKY: Use the first sentence, then review, limit and rationalize.

DR. KEMPER: And the bullets in the text.

DR. WILENSKY: Thank you very much. As I indicated we'll review ESRD after lunch. Why don't we start with the first of the hospital payment. David?

MR. GLASS: Good morning. This is to introduce the hospital readmission analysis which will eventually appear in the June report. So this is not a March report issue. We're just looking at some preliminary results here so we don't want to get too attached to the numbers.

Our objective here was to first determine if there had been a change in the PPS hospital readmission rate from '91 to '97 where there's been a significant change in length of stay and some other measures. If there has been, we want to understand where it is in terms of what particular DRGs

have been affected, what hospital types, perhaps what regions of the country it's occurred in. And we, of course, want to understand why and see if it's correlated with changes in length of stay, or discharges, or the use of post-acute care.

So here are the preliminary results. Readmissions here is considered as a percent of initial admissions with live discharges. So we're looking at initial admissions and finding what happens to the people when they're discharged, do they end up being readmitted to the hospital in three days or seven days or 30 days. The most obvious point here is that the rates have gone up. For the three-day readmissions in particular, instead of 2 percent of the discharges being readmitted, it's up to 2.5 percent. And the change there, rounding, is about .6.

The question now, is that an important change or not? You see it's repeated in the seven and 30-day rates also increasing. But most of the change is concentrated in that three-day period, which is maybe somewhat suggestive.

DR. LONG: David, is this the same DRG or any DRG?

MR. GLASS: These are all DRGs here.

DR. LONG: So for any diagnosis?

MR. GLASS: Right. So that .6 looks somewhat small, but then it's a pretty noticeable change to be considered as a percentage of those readmissions, 30 percent, and it translates to about 45,000 additional admissions, if you will.

One way of thinking of has this been a big change or not is to look at some trends. This is looking in '84, '86, and '88. This is from work ProPAC did. They had calculated readmission rates. They didn't do a three-day, but they did a seven-day and 30-day rate. If you look at that, it appears that they're kind of bouncing around 4 percent through the late '80s, maybe also into '91. There's a small methodological change between the ProPAC method and the method that we use for computing the readmissions. It shouldn't have a significant effect. It may increase ours relative to theirs a little bit.

So I think you can say that the late '80s to '91 it seems to be somewhat constant, maybe trending up a bit in '91, both seven and 30 days. We also put average length of stay there, which just coincidentally happens to tend to be correlated fairly well. When the length of stay goes down, the readmission rate goes up. So that's kind of suggestive

and that's part of what we want to investigate.

What this tells us is that the change from '91 to '97 really does seem to be a significant change and certainly out of the trend that we've been seeing. You can see that as the readmission rates have gone up, the average length of stay has dropped significantly from '91 to '97. So we want to understand what might be causing this increase and what's going on.

So for our next step we're going to investigate the distribution of the increase. We're going to look at all DRGs and see if there's some particular ones that are perhaps high volume and high cost DRGs that have significantly unusual changes in the readmission rate.

As an example of that, this is just looking at a particular DRG. This is DRG 14, cerebral vascular disorders. It's a fairly high volume DRG, 278,000 initial admissions in '91. We also put up transfers, which is when a patient is discharged and goes to another PPS hospital within 24 hours. And that rate went down a little bit. The readmission rate went up in almost exactly the same way as the average.

So you look at this one and say, this doesn't seem

to be driving that rate change. It seems to just be reflective of the overall rate change. And this is the type of thing we're going to do is look through a number of DRG examples and try to see if we can isolate ones where there's been a major change that's different from the average.

The drop in mean length of stay here again is large, but that's true for the average as well.

DR. ROWE: A couple of thoughts on this, David. First of all, I think as the physician members of the staff will certainly tell you, readmission is most commonly a problem in cases in which people have a chronic disease in a vital organ in which their reserve is limited. There are two such diseases, congestive heart failure and chronic respiratory disease. It's those two groups of patients who are right around the margin of being able to sustain themselves at home where modest changes occur and induce readmission. Congestive heart failure is the classical leader in readmissions.

So you should particularly focus on congestive heart failure and chronic lung disease. If somebody is at home on oxygen or with chronic lung disease, and then they get a little bit of bronchitis, or a little bit of the flu,

or a little bit too much or too little medicine and it tilts them over.

I see little value to an all-DRG analysis because there's just too much noise.

The second thing is, I think this is an area in which a change in the age of the population from 1991 to 1999 will be potentially significant. This was brought up earlier in the context of a shorter time period with respect to another dependent variable. It was felt with medication use not to be a problem or an issue. But I think in this case this may be an area where that's going to be an important component, in addition to post-acute care being an important component, et cetera.

The third thing is, if I had a nickel to spend, I wouldn't do this analysis. I don't think this is really going to inform policy. It's interesting. Somebody might do it for their master's degree or something. But I just don't think it's going to really inform policy so much at our level. But if we have to do it or if people think it's going to be useful, that's fine. But it just seems intuitive to me what we're going to find.

DR. WILENSKY: I think one of the questions that

maybe, David -- I assume these are not age adjusted, but you could have age-adjusted readmissions. The reason it's a policy issue is that there has been some policy concern that as length of stay goes down you may be driving readmissions. So it would be an inappropriate response. That's really what you want to see is whether or not what you are seeing appear to be medically understandable -- maybe not acceptable -- as opposed to reflecting the design of the policy system that you've put in place.

The question is certainly asked. There had been a presumption when DRGs were first put in place that putting in an admission payment would drive readmissions up because you can try to make up for the shorter stay by increasing the volume at the margin. One of the reasons that prohibitions, in terms of repayment, were set within a given timeframe was to attempt to try to prevent that. Now that has never been observed, with a lot of explanations as to why, or that's not been very much observed. But the issue remains one that I think we will probably be asked to address and providing negative information.

MR. SHEA: I think having seen the numbers, we have to do the analysis, otherwise Gail is not going to have

the right answer or any answer to the question when it gets asked. It certainly will be asked by somebody on Capitol Hill. My question was the same as has been raised earlier about the age. I take it, David, by your no-comment that these are not adjusted for age.

MR. GLASS: No, they are not. We just got the data this week in fact. We're starting on the analysis. But we can certainly look at the age adjustment.

DR. LOOP: I think this is going to be a very interesting investigation. We wrote a paper in 1989 which showed -- now this is a little dated because this is before balloons and stents and thrombolytic therapy. We found in looking at some of the -- I agree that you should concentrate on the most frequent DRGs, not everything. We found that half of the readmissions were planned elective readmissions. So someone came in, had a diagnostic procedure, left the hospital, went back.

Now that probably has changed today. I'll give you this paper, by the way, at the end. I think that this will add to our information about hospitalizations, the changes. I don't know whether it will affect policy but I think it will add to our knowledge about hospitalization,

and particularly the trend in changes in hospitalizations.

DR. ROWE: That's interesting. You might even define those cases differently. They're not really a readmission. If somebody is coming in for another --

MR. GLASS: There's no way of knowing if from the claims data though; not that I know of.

DR. LOOP: One thing you should decide here, at least to launch David in the right direction is what kind of a cut he's going to make in the DRGs, because you will pick up a lot of noise if you try to study everything. This paper that we wrote was just related to cardiac surgery, cardiologist, and gastroenterology, because we couldn't process the enormous amount of data if we covered everything. I'm not saying to do it that way, but I think you have to limit your investigation.

MR. GLASS: What we're going to do is order the DRGs by change in the admission rate and then isolate some that are of interest.

DR. LAVE: I think that my comments are going to be, to some extent, variations on the theme. First of all I like this for the reasons that had been mentioned, but also because I've been asked by a number of people, what's

happened to readmission rates? They're interested in what's going on. So I think that for a number of other people who are benchmarking and other things that they will like this data.

The second thing is with respect to hearts, I can tell you that we looked a little bit at the Pennsylvania data and that we've been trying to develop these episodes of illness sorts of things. That's neither here nor there. But the issue is that there are a lot of people who we put into the same episode if we use a longer period for that, and they're often transfers from rural hospitals to urban hospitals for surgical procedures. So you can't really tell whether something is planned or not planned.

But if you an have an AMI, some period of time, and then you have a bypass, you kind of know for that. And there may be other conditions for which there are follow-up surgical procedures for which -- what is really a transfer, but it's not a transfer because there's a break in time -- is really a continuation on the same episode, as opposed to -- for different expansion of the treatment as opposed to, I got out. I got sick. You sent me out too early. I came back. And you probably can tell a little bit by what

happens in the alternative, what's going on.

MS. RAPHAEL: I also think this is a valuable study. And in the continuing effort to destroy our silos, we are one of the 50 agencies that participated in the national OASIS demonstration. Interestingly enough, one of the areas we've been very concerned about was the readmission rate for CHF. We have been trying to understand whether we should be concerned about it or whether in fact this was something that would be normative. And we in fact have a goal to try to reduce the readmission rates because we think the may be too high.

So I think it's also worth looking at what we're learning on the post-acute side because there is now considerable information on readmission rates.

MR. GLASS: In addition to looking at this by DRGs, we're also going to look at it by hospital types and location to see if there are any patterns there, and investigate correlations with change in lengths of stay and discharge destinations. The discharge destination is probably going to wait until we get our episode of care database underway because then we'll have more definitive information on where people go after they leave the

hospital.

We'll look into other possible causes such as changes in DRG mix, and severity changing perhaps within DRGs. If we discover that people are being discharged quicker and sicker, which is, of course, the concern, then determine whether there are any payment implications. So in other words, has the product changed such that we need to make a payment change?

DR. LONG: I'm not as enthusiastic as others about spending scarce resources on this direction given however many reports it is that the Commission is supposed to do in the next few months. And all our paper says is we're looking at this as an indicia of quality. We've already mentioned that there's still apparently a nagging concern about payment game-playing and unnecessary readmissions I guess.

But just look at the DRG-14 data that was put up there, just back of the envelope numbers, from '91 to '97 we have reduced the number of patient days spent treating this diagnosis by over 1 million days in an expanding, aging population. Even if 100 percent of the differential readmissions had mean lengths of stay double the current

mean length of stay, you would have fewer than 100,000 additional patient days. So in the worst of all possible worlds we would have reduced patient days by over 900,000. So I'm not sure what it is we're looking for here, if we're trying to find something wrong.

DR. WILENSKY: Again to reiterate, the issue that was raised when DRGs were put in place is that having put in place an incentive to cut down days you would also encourage gaming of various sorts. We talk about upcoding, downcoding, right-coding. And readmission is a more drastic measure, but not one that people have wanted to put off the table. And it also has the issue with regard to some diseases like congestive heart failure as a reflection of potentially problems in avoidable problems with regard to delivery of health care.

So I think the set of reasons that we have looked at this is really a combination of inappropriate response to program design, which we will be asked to address whether or not it's there or not, just simply it's absence. But also some of the issues like with the congestive heart failure, whether or not this is indicating something that could have been handled better in some other way and some other --

diabetes may also be one. So it's some of the ones which may be used as sentinel effects, particularly readmission, or at least suggest for further follow-up.

But I think the notion that David had indicated of looking at frequency of readmissions and looking -- it ought to be two things. One, where's the action. And the second is, certain DRG classifications are ones that you'd like to look at to see whether or not there's something going on. So I think it's a combination of both letting the data tell you where the action is and thinking, a priori, where you might find an issue that you think would be important medically.

DR. LOOP: To our surprise, we may find something right in medicine. We're not really looking for something wrong all the time.

DR. WILENSKY: Yes. And just being able to be responsive to something that we know we will be asked about.

MR. GLASS: Actually, we were surprised to see the increase. That was the first thing that happened was, oh, there has been an increase, because that was not a foregone conclusion when we went in.

Another possible reason you might want to look at

this is that previously the PROs were reviewing all readmissions I think, and apparently that stopped in '94. So that may have had some effect as well.

MR. ASHBY: If I could, just for context here in response to Hugh's point. While it might be true that if readmissions are increasing, the implication for the total number of patient days is rather modest, I think it's worth reminding ourselves that the implication about payments don't run parallel to the implication on days. Because when you reduce [inaudible] --

DR. KEMPER: Whether this is useful or not to me depends upon readmission is a good or bad thing and whether we really know it or not. It strikes me that the only way you could really do that, come to a conclusion about that is looking condition by condition and trying to see if there's -- do two things. One is see whether there's anything in the claim that would be an indication of whether it's an avoidable condition that resulted in the readmission.

Secondly, look at other factors that might have led to a higher readmission rate for the condition. Change in technology which meant that something that wasn't treatable in the past is now treatable. So in the first

case you identify, and in the second case you treat it. But not being a clinician, as Jack will be quick to tell you, I am not able to judge whether that's even a line of judgment about the readmissions and whether they're indicators of quality problems or not.

My second comment is along the lines of Jack's with the aging of the population. The other thing that's happened is enrollment in managed care, and we know that there's favorable selection -- whether the remaining population in fee-for-service is sicker and therefore subject to more readmissions. Frankly, I don't think either the aging or the shift to managed care is likely to be big enough to explain it, but it's something that at least some sort of back of the envelope calculation might be useful.

DR. NEWHOUSE: I want to somewhat continue along the lines Hugh and Jack Ashby started. Assuming, as you stated out, that at least some of the readmission increase is causally related to length of stay falls then, as Hugh was I think presuming and Jack was presuming, then there probably needs to be some analysis of what the payment and cost factors are that would have to factor in the cost of the additional post-acute from the length of stay, and it

would have to implicitly -- I think one answer to Jack's point, the first order of point of correct. But that some of that has come back in the form of the lower updates from site of care substitution.

But the general point is that there is some tradeoff between the readmission rate and overall payments, and that's kind of the point of quicker and sicker. And we probably need to draw attention to both sides of the equation.

The other point is that although overall we don't think we had a lot of coding changes in this period, at the level of the specific DRG, it's not so clear to me. And I don't know how you would do this, but if I were on Jack's study section, I would worry about whether you had difference cases in specific DRG, particularly whether coding of comorbidities in the adjacent DRGs had changed, and analyzing readmissions.

DR. ROWE: Just to respond to Peter's suggestions or questions about what the role of different factors would be, technology for instance, and others, in determining the readmission rates. My guess from the literature and my personal experience, while technology is important,

particularly new medications, approaches to anti-coagulation, and things like that, the two most important factors are things that one you may be able to measure and one you won't.

One is the availability of post-acute formal care. The second, which is probably the most important, that you won't be able to measure, are social factors. Changes in informal support system. Whether the daughter is there to take care of the patient at home at night, whether they can afford to have people around the clock, et cetera. These kinds of social factors of who's around the house and who isn't, and these multiply impaired frail elderly patients coming out of the hospital with chronic lung disease or chronic lung disease, need dietary supervision, need to get their medicines on time, they're on a complex medication regimen.

And when those social factors start to fall apart, and resources aren't available, financial or otherwise, for post-acute care, bam, the patient's in the emergency room.

So you'll be able to look at the home care program issues but it's going to be harder for you to assess the social factors, which the older you get, the sicker you get,

the more important you get. So that's just a context, some of what we can measure and some of what we can't.

DR. WILENSKY: It seems to me the sense of this, David, the first thing is there something there or not? Is there something we can observe, age-adjusted? My guess is, as Peter suggested, probably whatever is being picked up by any changes in the managed care population and the aging is not going to impact it, hasn't been great enough in this period that you're looking at in the '90s.

And either there is something that suggests it's worthy of some follow-on study, to try to see if we can tease anything out of it, or there's not. But as I've indicated, it is a question that does get raised in a policy sense and, I think occasionally, in a clinical sense, and goes to the issues about the design of some of the current payment systems.

So it seems to me, on all those levels, it is appropriate to see whether there appears to be something going on. And the answer is it may be something very small or maybe not anything that we can really see going on. Or whatever it is isn't easily disassembled in terms of which of these various factors we've raised could be explaining

the change.

But I do think that, at least the kind of level of discussion that you've been suggesting, would give us that first answer.

MR. GLASS: So we'll proceed with it then at a modest level.

DR. WILENSKY: Yes. Thank you. We're going to do the PPS-exempt and then we'll do the other one after lunch.

MR. ASHBY: As was noted earlier, Janet is suffering from some laryngitis from the flu. Nothing has changed since this morning. I am once again subbing, as Beth did this morning. So please bear with me on this material that Janet is more familiar with.

Let me start with a little bit of background here, really just review. TEFRA exempted several classes of hospitals from PPS back when the hospital PPS was put into effect in 1984, basically because they lacked appropriate classification systems on which to base payment.

So these facilities are, and have been every since '83, paid their average cost per discharge, subject to a facility specific limit that has been known as the target amount. They also get bonus payments if their costs come in

under their target, and they get so-called relief payments if their costs exceed the target by a certain amount.

BBA made several important changes that do come into the picture of considering update recommendations. First and perhaps foremost, the bill capped the target amounts for the first time at the 75th percentile. So we now have a three-way determination of payment. They are paid the lower of their costs, their own facility specific limit, or the 75th percentile of the limits of all facilities.

Then the bill implemented a table, if you will, that linked their updates to financial performance. This is a phenomenon that is unique in fee-for-service payment policy. This is the first time that we have essentially legislated updates to margins. We've talked about that numerous times over years, we should look at margins as relevant information. Here we can clearly gone one step further. The law says if your margin is very low you'll get a higher update. If your margin is very high, you will get a lower update.

Then the bill also required PPS for rehab. That's coming down the pike next year. And it required a proposal

of PPS for long-term care hospitals.

If we move on to the next graph, we see that the margins of PPS-exempt facilities have increased rather substantially over the years. It's since 1990 that we're taking a look at.

Particularly in the case of long-term hospitals, that's the lower of the three lines there, we've gone from very low margins, minus 30 percent or close it, to modest positive margins.

There are two general phenomenon that we think are behind this trend. First, and again I suspect, foremost of the two is the difference between new facilities and old facilities. The general issue here is that when a new facility comes in they have their base payment established on their cost in their second year of operation. And actually, I believe it's their first year of operation in the case of a hospital unit. So they have the opportunity, obviously, to come in with very high costs per case, which is likely to happen when you're now. You don't have very many patients, you've got a scale problem. And then you are allowed to essentially keep that very high base. And it protects them against the impact of the limits over time.

Let's go on to the next table, that shows the difference between new and old facilities. In all three of the categories the 1997 margins are higher for the new facilities than they are the old facilities. And note particularly that in the long-term category, the difference is very wide. This is the category for facilities where the newly operated facilities has really driven their financial performance.

But I did want to note that the BBA did respond to this new/old hospital facility. It was this problem that prompted the differential updates. The theory was if you have an unusually high margin, it's probably due to being a new facility and we will reward you with a lower update, if you will.

They also did a second thing that's rather important, and that is they capped the ability of facilities to come in with a high base cost. Their initial base is now limited to, I believe, 110 percent of the mean of applicable facilities, facilities in their class.

The second phenomena going into the rising margins is length of stay declines. Of course, this has a familiar ring to it. We have been talking about this with PPS

hospitals for several years. And it also is a factor with the exempt hospitals.

In fact, if you'll notice on this chart, it is rehab facilities in particular that have had a very large decline in length of stay. And in fact, a larger decline in length of stay than even the PPS hospitals over the course of the '90s. In the other two groups, the drop has been rather substantial, as well.

Length of stay declines, of course, lead to low cost growth, all else being equal. And you'll notice, in the rehab category, the effect is rather evident. They have had an average cost change of minus 1 percent per year over the entire '90s. That's the cost impact of length of stay decline.

Now I did want to note, though, for context here that with the PPS hospitals, we have the issue, the problem if you will, that when length of stay declines, it lowers the hospitals facilities but the payment stays the same, literally unaffected. That isn't quite the case here, given that the payment is cost-based, when your costs are reduced due to the length of stay decline, your payment is reduced along with it.

Except that what has happened over the decade is that, in apparent response to the length of stay decline, fewer facilities are now subject to the limits and more facilities have qualified for bonus payments. So indeed, it has contributed to a situation where payments have been rising faster than costs.

I think we're ready to go on and look at the update framework. First, a couple of notes about the framework itself. You heard me talking yesterday about our desire for a generalized update framework that with customizing we can use across different categories of PPS's.

Here the customizing is a little bit more extensive because of the fact that we don't have a patient classification system in effect for these facilities. That's the first one. That essentially prevents us from having a case mix component to our update framework. We really don't have any information on how case mix has been changed, and therefore upcoding is obviously not an issue, and so you don't see it up here.

The other difference is in the S&TA category. We don't have S&TA net of productivity improvement here. We have left productivity out altogether under the theory that

here when you achieve a productivity improvement, your payments will go down along with your costs. That is the implicit productivity factor, if you will. We didn't think we needed to adjust for it again in the update framework.

So those are the two primary differences.

I'm sorry, Janet is reminding me, of course, that we also -- at least at this point in time -- don't have a site of care substitution factor as well. The declines in length of stay raise the issue of whether we should be looking at where these patients go upon discharge from these facilities. Anecdotal information suggests that there has indeed been an increase in the use of other forms of post-acute care after discharge from these facilities. And we do want to take a look at that when our episode file comes into effect.

But at the moment, we don't have a site of care substitution factor here either. Question?

DR. ROWE: This still continues to include children's and cancer hospitals?

MR. ASHBY: Yes, the update will apply to them.

DR. ROWE: Are there any data with respect to cancer hospitals or children's hospitals that are specific

or different, because data -- they are obviously very different facilities than rehab facilities and chronic hospitals. And what we're doing is doing an analysis based on a large number of rehab facilities and site facilities and taking that result and applying it to acute care cancer hospitals.

MR. ASHBY: Not only an analysis, but the law itself, of course, does the same thing. I think you're making an excellent point. Much of the provisions of the BBA were in response to the new/old hospital issue. Well, how many new children's hospitals do we have? How many new cancer hospitals do we have? Actually, there may be some new cancer hospitals, but they're not in the exempt category.

So much of what has driven policy is, I guess, it seems to me, not really applicable to these facilities. It's a very good point.

DR. ROWE: I think it would be interesting, therefore, to do an analysis, if you're doing an analysis and if you have the available data, of the cancer hospitals separately or the children's hospitals separately, to see whether or not the decisions that are being made on this

larger database make sense.

I have no a priori knowledge of whether or not the cancer hospitals would look like they need more of an increase or less of an increase, but it just doesn't make any -- it's really apples and oranges.

DR. NEWHOUSE: Jack, I think that comes in on the S&TA. We haven't gotten to a site of care yet. There may very well be a different -- what you're leading to is a site of care substitution would differ, which is very likely correct. But we haven't gotten to a site of care substitution adjustment yet.

DR. ROWE: I'm not sure that's right. I mean, they're just completely different --

DR. NEWHOUSE: No, the S&TA may well be different in those. I think there were nine and are now 10 cancer hospitals.

MR. ASHBY: There are 10, yes.

DR. ROWE: The second is that this includes units, you keep talking about facilities here. But you're talking about units within hospitals as well as free-standing facilities; is that right?

MR. ASHBY: We coined the word facilities to take

in free-standing hospitals plus units of PPS hospitals. And it does indeed apply to both.

I think the point about looking at children's and cancer a little closer is a good one. I think we should go back and put that on the agenda for this year. They, perhaps, have gotten a little bit of short shrift just because there are so few of them, and their number of cases are so small, in the case of children's. But I don't know if that's a great reason not to look at them. Perhaps we should.

DR. KEMPER: Do you have data on total margins?

MS. GOLDBERG: It's in the data that we have, but not in the printouts. So we'd have to run some additional data.

DR. KEMPER: I think that would be useful to look at in coming at this.

I guess I come away from this just scratching my head about what's really going on behind this, because unlike the other updates where all the hospitals are subject to the same set of rules, here you have a whole different set of rules, depending on the history of the facility and the nature of the costs, and so on.

And so when we look at the aggregate data, say on profitability, that might be a mix of some facilities that are very profitable and some that aren't very profitable, some that deserve an update and not.

I guess my biggest concern is it sounds as if there is, for the set of facilities that is truly cost-based, that is to say if they have shorter lengths of stay and their costs go down, their payments go down. Or vice versa, if their costs go up -- in other words, if they're not subject to any of these limits, for that group of facilities, don't they already get a sort of automatic update? And then another set of facilities that's up against the limit amount where they don't get any update at all, any implicit or automatic increase or bonus or whatever.

And so they deserve an update but the others may not deserve any update. Deserve in the sense of cost of efficiency.

MR. ASHBY: Right. One of the things that we have to keep in mind here, which was going to be my first statement as we look at the update framework, is that the update only applies to the facilities limit. If the

facilities cost is underneath the limit -- actually, I should say well underneath the limit, beyond where bonus comes into effect, then their payment increase is driven by their cost increase. It is truly cost-based.

So you're right, the dynamics are a little different and we have to keep that in mind.

DR. KEMPER: So they don't then get this update?

MR. ASHBY: No.

DR. LAVE: This comment I'm reiterating -- is that what we do when we're forceful as opposed to repeating? I am reiterating a request. This actually follows from something that Peter has said.

That is that my preference would be, in many of these things, where we talk about margins, is to also give some distributional data about the distribution across facilities with respect to what's happening.

I find sort of this concept of aggregate margins somewhat befuddling because you have very different things going on underneath. I'd like to know something about the median hospital or the median facility. I mean, you've told us something about young and old but even then again, the data there are in the aggregate terms for those facilities.

So I'm not exactly sure what distributional data, but I think that it would be very informative to have some distributional data behind the aggregate data that are presented, not only for these hospitals but for the regular hospitals that are subject to PPS, as well.

MR. ASHBY: We will do that.

DR. WILENSKY: Any further comments?

MR. ASHBY: Do we want to look at the framework again then?

First of all, my first caveat was the one I've already made. This only applies to the limits, and that's an important thing to keep in the back of our minds. Second is that we are not expecting to make the recommendation here until our June report. So this is a preliminary look at it.

You can do the extent of decisionmaking that you feel comfortable with, but you will, in any event, have an opportunity to revisit the decision before it becomes final and goes into our report.

But where we stand here is that, first of all, the forecasted market basket for 2001 is 2.8 percent. The way we have traditionally done correction for forecast error is that we are looking back two years, that is to '99, which is

the most recent actual data that we have available.

And it turns out that the actual market basket increase in '99 was the same as HCFA forecast at the time. And so the correction factor is zero.

Now for the S&TA, there's a little bit more to this than meets the eye, and I'm in a little of an awkward position here because we had originally planned to initially address this issue with the PPS hospitals and Nancy Ray was going to do these comments. So I guess I'm, in a way, substituting for her, as well.

That is, you'll recall that last year we took a look at Y2K issues in the context of S&TA. We posed the question of whether after the magical January 1 goes by, will there be additional Y2K related issues that hospitals have to deal with?

I think it's safe to say that, as of January 14th, we don't see any signs of it. But this is one of the advantages we have in holding this for a couple of more months. If something should materialize, we would be in a position to respond to it.

Comment on that?

MR. JOHNSON: Just on that, Jack. I think one of

the things that you may not have anticipated, though, is that people spent a lot more than they thought they were going to spend. It's not just computer systems, it's equipment, embedded chips, legal issues for protection.

For example, Peter and Gail know in Lansing, Michigan, we now have two hospitals there. Their figures at the end of the year, of expenditures for Y2K between the two hospitals, were $40 million, a fairly significant number in a small community. And as you go to some of the larger communities, the numbers run much higher.

So if anything, I'd say it's not an issue of are there going to be more expenditures, because we missed and we've got to go back and fix. I think the fact is between equipment, between computer and information systems, between consultants to come in and set these things up and change them, my estimate in our state, at least, is the people spent about twice as much as was estimated.

Now the result of that is there's no crises 14 days later. But on the other hand, if our premise on the update is well, since nothing happened we're not going to give an update, I think that really shortchanges what actually happened out there in the field.

DR. WILENSKY: We'll come back to this in our next session on inpatient. I think this issue about to the extent that there may have been a component error or an underestimate in the past, we can talk about whether or not -- as we sometimes do corrections -- whether that's something that we want to take up.

MR. ASHBY: So we'll defer that conversation to this afternoon?

DR. WILENSKY: Yes, because of the fact that it seems to me that it's not as compelling with the PPS-exempt hospitals as it may be within the general hospital world.

MR. ASHBY: On Y2K?

DR. WILENSKY: In terms of the extra payments. But I don't know whether Spence's comments --

MR. ASHBY: What do you think about that? On other S&TA, you're absolutely true, we've always kind of thought that. But on Y2K I wonder, is it really any different?

DR. NEWHOUSE: The units would presumably be part of the overall hospital effort.

DR. WILENSKY: Some of them are.

DR. NEWHOUSE: I understand, not the free-

standings.

DR. WILENSKY: I guess I'm thinking about -- and it just may be more of a question of whether or not we might need to try to see estimates. These are just a different class of hospitals. And whether or not, whatever goes on in the general hospital world, we ought to try to see whether there's any indication of whether Y2K spending for this PPS-exempt class of hospitals was about the same or less for whatever set of reasons.

DR. ROWE: With respect to that -- I'll reserve to this afternoon my comments about Y2K in general. I think that these hospitals are less likely to have had the kinds of expenditures. Our expenditures were in the ICUs, in the operating rooms, the recovering rooms, monitoring areas of coronary care units, where we spent, in our hospitals, $34 million on this issue.

We can talk about how much of that we would have spent anyway. Some of it was just equipment that we replaced a little earlier than we would have otherwise, et cetera. We can go back and forth. We'll explain what we spent and why.

But I would agree that these hospitals, which are

the rehab, psych, are not immunized completely from these issues, but somewhat less technologically intensive. So I think we have to say that.

MR. ASHBY: That's a good point.

DR. ROWE: Forgetting Y2K -- thank god we're able to do that -- I think that the S&TA, you're taking the productivity out because you're saying that feeds back to lower payments anyway. So this is not an S&TA discounted by the productivity?

MR. ASHBY: No.

DR. ROWE: This is S&TA. And so I want to look at the S&TA level of zero. I want to ask you what the trend has been over time, over the last several years, as to what that S&TA was if you add back the productivity discount, because it's not in this one? In other words, what has that number usually been over the last three or four years.

MR. ASHBY: For PPS-exempt hospitals it has been zero in our update recommendation for several years.

DR. ROWE: Is there ever a point at which you think there are some scientific and technological advancements?

MR. ASHBY: I was going to get to that. We did do

some looking into this where we could. We made some calls to two different organizations, did a little bit of literature search, and really did not uncover anything significant, substantial that related to these facilities.

And so we've generally sort of continued with the thought we've had previously, that most of the significant expenditure of dollars for new technology has been in the acute care hospitals. It sort of parallels your Y2K comment, actually.

DR. ROWE: If that's your analysis, all I would want to say is we should be mindful that, just like the Y2K experience may be different in the acute care hospitals, this may be different in the acute care hospitals. And whatever decision is made with respect to this isn't necessarily driving this issue with respect to the other hospitals?

MR. ASHBY: No, and as you'll hear this afternoon, we did not treat it the same either.

The other comment I'd make by way of background is that several years ago we did do actual sponsored research of S&TA measurement. And we did do that separately for the exempt hospitals, and we got a minuscule measured amount. I

think it was like .1 percent or some such, along that line.

It didn't even round to .1. It rounded to zero.

DR. WILENSKY: And not in the rehab, either.

MR. ASHBY: No, at least not at that time. Of course, the rehab field has changed rather drastically the last few years.

DR. WILENSKY: That's the only one, at a sort of an intuitive level, I'm not surprised that you weren't picking anything up maybe on long-term care and psych. I'm a little surprised that some of the inpatient rehab would have had --

MR. ASHBY: No. I would not want to guarantee that we would find the same thing today in rehab. And that's part of the reason that we at last tacked the .2 on to here. There's uncertainty, because of the fact that we have not measured this recently. There's also uncertainty in the sense that the S&TA measurements always looked at significant major developments.

We could never really capture all the small ticket stuff. And I'm comfortable with the conclusion that it is literally zero, in light of these small immeasurable things.

DR. ROWE: We'll give you a card, Jack, that says

if this patient is ever admitted to a rehab hospital he should not get any advances in care that have been introduced since the year 1991. Would that be okay?

MR. ASHBY: That's kind of the point. But not any, it's so stark that it really leaves you with an uncomfortable feeling.

DR. LAVE: I don't know about the literature research, but I would imagine that one of the reasons that it hasn't been this huge problem has to do with the fact that there's been this decrease in length of stay. So that it's very difficult analytically to cross off the effect of the decrease in the length of stay. Since that's not being in there, it could have been that the decrease in length of stay, had there been no, would have had a bigger effect on overall costs.

DR. ROWE: In the PPS-exempt units would that be as important?

DR. LAVE: I'm just saying that one of the reasons that we, I think, are not observing -- where you would observe it would be cost pressures pushing you up against the limit, and you would be observing a lot of hospitals might be having trouble because they were implementing

science and technology, and you might have sort of an ah-ha kind of thing.

But if you look at what's going on, you've had this significant decrease in the length of stay. And you have had a consistent update, so that you've had some leeway in those facilities for improvement in technology. So that Jack doesn't really have to go and get 1990 technology. He can go and get 2000 technology with a good conscience.

DR. ROWE: Why do you think there's been a reduction in length of stay at places that PPS exempt?

DR. LAVE: It's probably to do with science and technology?

DR. ROWE: No, it's because Medicare is not the only payer and the other payers have strict limitations and the length of stay that they'll pay for. And so you build in a system because managed care payers and other commercial payers, et cetera, don't treat these as if they are exempt from these restrictions. That's the reason. Nothing to do with the science and technology.

DR. WILENSKY: We don't have to make a final decision on whether we want to include this, but the notion of having some leeway that people can think about when we

come to make our recommendation, I think, is appropriate.

MR. ASHBY: So we're at a point where we can leave this chart and pick it up?

DR. WILENSKY: I don't see -- unless want to discuss the issues anymore -- that we need to do more.

DR. KEMPER: I just hope that -- in the background here is this dramatic increase in Medicare margins. And the story you've told is that payments are either being capped by this limit or being adjusted to actual costs because they're really based on a cost reimbursement level.

So some explanation of why that's occurring and whether that should affect our update thinking, seems to me important. In a couple of areas, Medicare's two-thirds of the business. So Medicare's got to have a lot to do with what's happening to that.

And nothing in the way it's written would explain to me why has there been that dramatic change, and should that affect --

MR. ASHBY: Change in [inaudible]?

DR. KEMPER: Yes.

MR. ASHBY: I think broadly speaking, the length of stay drop and the introduction of the new facilities with

high bases does explain a lot of it. But there is more detail behind that, as you said, because you have one set of facilities that are affected by the limits and one set that are not, and they're having different experiences.

DR. KEMPER: So if we looked at the old ones, we wouldn't see this increase in margins?

MR. ASHBY: Oh yes, we would, but lesser so. That is one of the analyses that we wanted to come back with next time. We want to look at the trend in the new and the old separately, because that's the way you tease out effect of length of stay from the effect of new facility. So at a minimum you want to do that.

Secondly, we want to look at the distribution and that means monitoring what's happening with those who are up against the limit versus those who are not.

DR. KEMPER: But it just strikes me that somewhere in the payment, in these complicated payment details and bonuses and so on, something is going on to raise the margins. And if you could shed any light on that, that would be helpful.

MR. ASHBY: We will try to be more specific [inaudible].

DR. WILENSKY: Commissioners, is there any other comment? We're going to break for lunch. I think we're down where we were yesterday. We can either reconvene at 1:00 or 1:15. I think it will take 30 or 40 minutes to go through the session and I would like you to see the ESRD recommendation, to see whether we're capturing it.

Again, my main interest is in keeping you here to have input on this, so 1:00 is fine. We'll reconvene in public at 1:00.

[Whereupon, at 12:21 p.m., the meeting was recessed, to reconvene at 1:00 p.m., this same day.]

AFTERNOON SESSION [1:24 p.m.]

DR. WILENSKY: Tim?

MR. GREENE:

Good afternoon. Now we're turning to the update for PPS hospitals, PPS inpatient payment rates.

A brief background on the update. As you recall, the operating update is set in statute by the BBA. On the other hand, the capital update is set by the Secretary with discretion, set through the rulemaking process. This year we'll be having a single update, a combined capital and operating update, consistent with the recommendation you made earlier.

Though the operating update is set in statute, we take the position that the Congress looks to the Commission for advice on the appropriate level of the operating update and an evaluation of the capital update, as recommended by the Secretary. So the Commission has always made recommendations for a level or a range for the operating update and published it in its March report.

This year, we're considering a change there. With the June hospital payment report coming out, we're planning to publish the update recommendations as part of that

document. So the important consideration here, which I'm sure you thought about but I want to re-emphasize, is there's no decision to be made at this point.

This is, in a way, a background briefing, for information that you'll be hearing again in March or April, at which point you'll be considering the PPS update recommendation.

We think and hope that the information you'll be hearing now will be very similar to what you'll be hearing in March, and that what you hear today will be useful as information then. We don't expect the numbers, the market basket numbers and others to change dramatically, but I'll have to emphasize that this is all preliminary information at this stage.

Postponement of the update decision until March has a number of advantages. First, we'll have new data available at that point. As you know, data is not currently available on PPS margins. By waiting until March or April, we expect to have data available that will tell us something about the impact of BBA as reflected in PPS and total margins in 1998.

Second, we are undertaking a study of real case

mix change, using data abstracted, collected by HCFA, where contractors reabstracted medical records and then assigned DRGs to these records. We're using that as a basis of developing a measure of upcoding.

This is parallel very much to a series of studies that were done at Rand in the late '80s using the similar files of reabstracted data, but that's gotten rather old by now. Now we're talking about information from 1996 through 1998 and perhaps through 1999.

Moving on, an overview of what we'll be doing today. First we'll be presenting an application of the MedPAC general update framework to PPS inpatient rates. I'm not going to get into the details of the update framework, since you heard about that from Jack and you heard about it just a few hours ago as applied to the exempt hospital situation. I'll highlight areas where this application differs from that for exempt hospitals, but basically I'll be filling in the pieces.

As I indicated, we're talking about a combined payment rate so we'll be framing things as a combined payment rate and I'll be discussing a combined market basket and estimates for that.

I'll be going over our preliminary information for net S&TA adjustment, which means our information on science and technological change on one hand and also our information on net productivity standard.

I'll be going over the site of care substitution background information and a range of possible values for this year and information on case mix adjustment.

I'll re-emphasize, this data is for information and is preliminary and I'm sure will be updated for March and April.

Starting with the market basket, I'm presenting here current estimates of market basket rate of increase for fiscal year 2001. What I'm presenting here and using for the purposes of this exercise is data from the HCFA market baskets, operating market basket and capital market basket.

I do have to note that operating market basket on the one hand differs slightly from the MedPAC market basket. As you decided in September, we wouldn't be making an adjustment for that difference now or in the future.

On the other hand, the capital market basket differs significantly. It may not differ greatly at this time of low and steady interest rates but it may differ more

significantly in the future.

What we're presenting here is essentially our first cut or an interim version of a combined capital market basket component. We may want to go back and look at that more carefully after the recommendation is prepared. That may be a topic for the workplan for next year, to give it a serious effort.

DR. ROWE: May I ask a question about this? Tim, how do you get to 90/10? How is that determined?

MR. GREENE: It's based on information on distribution of Medicare payments by capital versus operating. It's generally considered to be representative of the distribution of costs between capital costs and operating costs. I'm simply applying weights reflecting the relative importance of capital costs and operating costs to the hospitals.

DR. ROWE: The 10 percent seems a little high to me for capital.

MR. GREENE: Operating payments run at about 8 percent and they've been fairly steady in the 10 percent range for some time.

DR. ROWE: That may be for Medicare. It just

seems a little high. My budget is $2 billion and that would be $200 million in capital this year. We probably didn't do nearly that much. It just seems a little high for hospital capital. But if that's what the Medicare payment is, I guess that's what we should use.

You include debt service in the capital, right?

MR. GREENE: Yes. This is capital costs. This is not investment, this is capital interest and depreciation, based on interest and depreciation.

So briefly, for the current forecast for the HCFA operating market basket is 2.8 percent for fiscal year 2001. For the HCFA capital market basket it's .6, for a combined market basket of 2.6.

DR. ROWE: How does that differ from the 2.8 that we heard from Jack before lunch?

MR. GREENE: It's a different framework. It's a different market basket which was similar in many ways, but differs slightly. A different collection of components that are then --

DR. ROWE: So the PPS-exempt facilities have a different market basket that you sample.

MR. GREENE: Yes.

DR. ROWE: Even if they have are a unit, rather than a free-standing facility, a unit of an operating hospital. So you're saying like the psych unit or the rehab unit at a hospital have a different market basket. And the rest of the hospital take -- okay.

MR. GREENE: Yes. The other element in the price-related adjustments, apart from the market basket measure of price increase, is an adjustment for forecast error in past years. As we discussed previously, we don't want to reflect past errors in the future payment rates. We're always adjusting with a two year lag, so fiscal year 2001 update reflects errors in the 1999 forecast.

In this case, the net effect is to increase the update by .1 percent. So we have a total for price related elements of 2.6 plus .1 for 2.7 percent.

Moving on to the science and technology adjustment, here we've determined in our review of scientific and technological change in the acute hospital industry, we found no major change from last year. So we're recommending that we apply the same adjustment for general S&TA that we recommended last year of .5 percent.

The major issue, both last year and that you

talked about this morning, were Y2K computer costs. At this point, we suggest a zero percent adjustment for that, though. In the paper we mailed out, we suggested a range of zero to .5 percent, if you decided that was something you considered worth an adjustment.

Productivity standard was something you discussed in September. There you were discussing a .5 percent factor. We did our regular review of the productivity literature and determined that BLS data, Department of Labor data, on multifactor productivity in the economy, the non-farm economy, indicates a .4 percent increase, both for 1987 to '97 and for '96-'97. In other words, a pretty steady rate of increase for a comprehensive measure of productivity growth of about the number that you were recommending for as a productivity standard in September.

So the net effect there would be .5 percent preliminary science and technology increase offset by a .5 percent productivity standard for a zero percent adjustment for science and technological advance.

DR. WILENSKY: Tim, I just want to raise something because it relates to a comment that Spence made earlier about actual Y2K expenditures. While it may look like there

is a zero component, actually it's not true because the money that was put in went into the base last year as opposed to being a one-time contribution. So unless it comes out actually, although the Y2K expenditures are presumably time limited, the addition continues unless we take it out.

So we can think about it, and again we don't have to come to a --

DR. ROWE: What was it, .2?

DR. WILENSKY: .5. So it was not small, to have permanently in there.

MR. ASHBY: Could I put in a caveat to that, though? You wonder how to treat this, but while we did add the .5 increment last year and it was put into our range for the update, we then, in essence, sort of superseded the range by making a statement that the update in law would be appropriate. The update in law was .7 percent at the time.

And it's unclear that you would view that as large enough to encompass that .5 that we had in the range. So one might say that maybe we didn't give it to them last year and maybe we don't need to take it back out.

DR. WILENSKY: I wasn't suggesting we take it back

out, particularly, as much as saying that it may be more than having just tried to acknowledge last year the amount. So I wasn't really suggesting you take it out.

DR. ROWE: What was the range last year?

MR. ASHBY: We included .5 for Y2K.

DR. ROWE: We came down to a range. We decided on .7 but what was the range?

MR. ASHBY: Zero to 1.8, 1.9, something like that. It was a range that extended a ways beyond the .7 that was in law.

MR. GREENE: Two things about the base. We recommended a certain value for last year but what went into the base was what was determined by HCFA in setting the PPS rule. No matter what our recommendation was.

MR. ASHBY: No, set by Congress.

MR. GREENE: I agree. But what was issued as the final rule was what determined the base, not anything we said or thought about. But that points one way.

On the other hand, we need to remind ourselves about Y2K costs. We're making a recommendation for fiscal year 2001. We're talking about Y2K costs that may be continuing from October on.

DR. WILENSKY: I just wanted to raise the point that even though you may not add it in each time, depending on how you view what happened doesn't mean that it's only had a one-time effect. We can go back to discuss today, or in March or in April when we have later numbers, what if any different number we think.

But the fact that you see zero doesn't really suggest zero because of the way it -- whether or not you want to have it suggest all of what we recommended is something else. You have to go back to look at the various ranges for each of the elements we had to try to think about where we actually ended up.

DR. ROWE: Is there some way of getting an estimate from some third party, objective third party, of now that we know what did or mostly didn't happen at Y2K what, if any, Y2K relevant expenses there would be starting next October? Or I guess this October.

DR. WILENSKY: We can try to ask. I'm not sure there is such a thing. The issue that you raised is probably the trickiest one, which is in terms of expenses that were undergone, how much of these were expenses that would have been undergone and maybe were accelerated by

this.

DR. ROWE: I have to say in my experience that I think that Y2K was more expensive than we thought it would be but that part of that -- not all of it, but part of it was that we accelerated certain kinds of turnover of equipment and things just because we didn't trust what we had.

I don't think that accounted for all of it, but I think it accounted for some of it.

DR. WILENSKY: We can try to find out. The staff can look.

MS. ROSENBLATT: If we do that, there's another side to that which is that a lot of the experts are saying that the fact that there has been new equipment purchased and better equipment purchased that there should be greater productivity savings, which is to say that maybe the .5 percent is too low.

DR. ROWE: I think that if in fact buying new equipment actually does increase my productivity, I'd be happy to know that, and probably would buy more of it. I think that's reasonable.

MR. SHEA: I just had a process question. Do we

have any way of looking back and correcting for any of these categories, as we do for the market basket errors?

MR. GREENE: We haven't in the past.

MR. JOHNSON: Actually I have several comments about the whole formula, so I don't know if you're done. You go to productivity? I guess I'll wait until he finishes.

MR. GREENE: Next I'm turning to the site of care substitution component, which has been a major part of --

MR. JOHNSON: Gail, I didn't know if he was done.

DR. WILENSKY: I don't want to have a general discussion. I had raised this as a clarification to how to think about the zero. We'll come back and open it up. We'll come back and have a regular discussion.

MR. GREENE: As we discussed on many previous occasions, the Commission has made an adjustment for change in site of care the last several years. Average length of stay Medicare inpatients has declined 27 percent from 1991 through 1997, the most recent data available. Our most recent cost report analysis found a minus 3.4 percent decrease from '96 to '97, which is new data compared to last year.

We believe that a good deal of this decrease has been accompanied by increased care in rehab hospitals, SNFs and other locations for which Medicare is paying for service even while payment for PPS hospitals does not decline proportionately with declines in length of stay.

One point we can see here, the second line from the top and the very bottom are Medicare data. So what we see there is substantial drop in length of stay accompanied by a moderate drop in costs per discharge for Medicare cases.

Now we supplement that with information on all payers from AHA data, panel survey data. Looking at the next set of lines, we see a decline in costs per adjusted admission, more or less paralleling the Medicare pattern and a decline in total length of stay, length of stay for all patients, which also parallels but is more modest than the Medicare decline.

It's useful because though we don't have Medicare data for the '97-'98 period, we can see from the past similar pattern, we can guess more or less what the Medicare data will be showing when it comes in. We'll be seeing continued decline in length of stay and cost.

Just for clarification, remember that length of stay decline numbers there, the ones on the bottom, are rate in change. We're not saying an increase in length of stay, and since 1995 just a moderation in decline.

I've found in many presentations and discussions that loses people. They look at that and they say oh, length of stay is going up again. No, it's not, it's just not declining as rapidly.

We were hoping to have information from the new hospital indicator survey, the new survey we've been sponsoring with American Hospital Association and HCFA. The data is just not available at this time. There's data in-hand but just not considered -- examined closely enough and reliable enough for us to present. So my apologies on that.

This is the steps we've gone through to get the site of care substitution adjustment we would consider suggesting you consider it for this year. First we emphasize the whole length of stay decline is not due to site of care substitution. Some is improved performance, increased efficiency in hospitals and so on.

So though we estimate a cost reduction associated with the actual length of stay decline, we make an estimate

of about 10 percent, which would be attributable to site of care change, site of care substitution. That would be the maximum amount that one might want to adjust payment rates by.

DR. ROWE: That's over the whole period of time?

MR. GREENE: Yes. That's cumulative.

Now we calculated that we've already made adjustments to payment rates that we could describe as site of care adjustments equal to about 6 percent over the period. We'll be getting to that in a moment. That's based on a comparison of what the actual updates have been versus the updates that will be justifiable using the MedPAC framework for price change, S&TA, and so on.

That leaves a 4 percent adjustment still to be made, and we would suggest considering a 1 to 2 percent adjustment per year for 2001. So that would be the number that we would consider based on our data for inclusion in the framework.

This overhead, which we also include in the chapter and is discussed in detail there, lays out the steps we went through to get that 6 percent adjustment already made. Simply a comparison year by year of the actual

updates in law and implemented versus the update that would be suggested by your framework including all factors other than site of care substitution.

In 1999 the actual update was 1.1 percent less than would have been suggested by the framework based on the things we consider appropriate, which suggests that, in effect, we made a 1.1 percent reduction in payments that goes towards reducing the payments for site of care substitution. The total for the three years plus the effect of expanded transfer policy is minus 6.2 percent, which compared to the 10 percent to be made gave us that 4 percent still remaining.

DR. ROWE: Are these changes made in the base also?

DR. NEWHOUSE: Yes.

DR. ROWE: So is there a compounding of these effects over time? So that you shouldn't actually just add the 2 percent you did this year and the 1 percent that year and the 1 percent the next year and it adds up?

MR. GREENE: This is the cumulative effect each year on the base.

DR. ROWE: More than or less than the sum of the

individual effects?

MR. GREENE: There's a cumulative effect, but it's trivial. Here it's 2 percent in the first year, 1 percent, and so on. If you did them like compound interest, you'd get a number slightly different than 6 percent.

DR. ROWE: That's my question.

DR. LONG: 4/100ths of a percent.

MR. GREENE: Moving on to the next overhead, we've always included an adjustment for case mix index change in the update framework. In particular, an adjustment largely taking account of upcoding in the hospital industry.

We've been struck by the data that's finally come in for fiscal year 1998, the most recent data available, on case mix index change. There we have, for the first time, a decline in the case mix index that we expected and that we were anticipating last year based on preliminary data, which is very clear now, of .5 percent.

We understand from analysts at HCFA that they anticipate comparable minus .5 percent decline for fiscal year 1999. So there seems to be no basis, given this data and given everything we understand, for an adjustment for upcoding change.

DR. ROWE: Would you assume, it follows I guess that you're recommending that there be an adjustment for downcoding?

MR. GREENE: That is a question, would you want to make a positive adjustment to the update on the grounds that hospitals are downcoding or billing too little. And that's a possibility. It seems more likely though is what it also suggests is there was so much upcoding in the system already that...

DR. ROWE: I'm really have a good time listening to this explanation for why we adjust for upcoding but not for downcoding. Go ahead.

MR. GREENE: The other point that I was going to make is we've also included an adjustment for within DRG complexity change, increases in case complexity and costliness not reflected in the DRG distribution and hence, in the case mix index.

For the last several years both ProPAC and MedPAC have made zero to very small .2 percent adjustments for that. And we have to admit we really don't know, based on information we have, we don't have any really hard information on within DRG case complexity change at this

time. So we'd suggest not making any adjustment in that area.

DR. KEMPER: Will you have information before the next meeting on that?

MR. GREENE: No. I suppose there could be things done by comparing APR-DRG and DRG adjustment.

DR. KEMPER: That's what I was going to suggest because if there's downcoding then doesn't the within DRG mix, isn't it likely to get more complex, more severe? I mean, don't they move in opposite directions?

MR. GREENE: Yes, it could. Depends on the nature of the downcoding. If it's DRG coding change it's one thing. If it's diagnosis coding change, preliminary assignment of DRGs, you might see that polluting both the APR-DRGs and the DRGs.

DR. ROWE: Is the upcoding age adjusted? I'm not thinking on an annual basis, but like over a 10 or 15 year period?

MR. GREENE: No, we're simply comparing average DRG weight, which is the CMI year to year.

DR. ROWE: Right, so average CMI for the Medicare population in 1998 versus 1988.

MR. GREENE: So in the long term it's going to reflect changes in the demographics of the population, as well.

DR. NEWHOUSE: We never assumed that all of the measured change was upcoding. Some of it was true change. So the aging would come in through that mechanism.

DR. LAVE: The APR-DRGs may pick up more effect of age because they may have more of the comorbid conditions that stick you into a different severity.

DR. ROWE: I was just thinking from 1985, where there was this ridiculous 5.5 percent increase, but there's probably some small number -- I don't know what it is -- over time, over a 20-year period with changes in the demographics, that influences this in some way. It's small but it's probably there.

What you're saying is the upcoding correction never ate up all the upcoding, so therefore there was something left which was felt to be real?

DR. NEWHOUSE: Right. The assumption was this would asymptote out at the true change, because short of outright fraud there was only so much upcoding one could do.

DR. ROWE: Hopefully.

MR. GREENE: [inaudible].

DR. WILENSKY: But they were not regarded as synonymous.

DR. ROSS: Jack, I wanted to respond on the aging phenomenon here. I haven't looked at it in the context of case mix index, but in other applications, and through the 1990s the last time I looked at this, if you tried to look at the effect of compositional change, it's very, very small.

DR. NEWHOUSE: I think it's an inverse "U" by 65 to 74, 75 to 84 and 85 up on the case mix. So the aging isn't going to have a simple effect.

MR. GREENE: Now realizing this is preliminary and so on, we're just laying out the update framework which you could, if you wanted, fill in. Or we could just leave for information.

This overhead, I realized this morning when it was too late, cut out the last two lines which was essentially case mix adjustment component, which you could just add on the grand total.

As I think you can see in the mailing material, there is one relevant item at the end that also wasn't cut

out that's useful in considering possible ranges. The actual operating update set by BBA and set in law for fiscal year 2001 would be 1.7 percent based on current market basket information. Capital update is not set in law so there's no 2001 number to compare it to.

We could either go through it or you can just --

DR. WILENSKY: I'll ask people if they -- Spence said he had some comments. But I want to be clear, that this is as much to talk about the framework. It's the framework we've had in the past. We will have what we think are appropriate numbers as we get new data.

We're not asking to give a recommendation or a decision now. But if you want an issue to be thought about during the time, this is the time to raise it.

MR. JOHNSON: I'll go back to where I was this morning on the S&TA which I think is, overly-generally, understated. I'm not sure I feel better by Gail's explanation or not, and Jack's response, about whether it's in there in a permanent way, whether it's in there or not for Y2K.

But also, as you've written in the chapter, you referred to we'll continue to watch the computer

expenditures. That's sort of thinking of Y2K in hospitals as your home personal computer. We're talking about physical plant systems. Did the lights come on? Does the water run? Does the emergency electricity come on? We're looking at medical equipment. We're looking at information systems. We're looking at quality systems.

And to sort of have this mental image that you look at what hospitals spend on computers and did they spend more than before Y2K, that's the expense, that's too simplistic. So just as you're writing it, I'd stay away from that.

A couple of other areas, we talked this morning -- in fact, I think Gerry mentioned that he had heard from a lot of hospital people about the impact of prescription costs over the last couple of years as pharmacy costs have really been skyrocketing. I can't believe, in this adjustment, that there wouldn't be some recognition for what's happening in pharmaceuticals.

Another area that I think you might look at is new blood technologies. There being a lot of things added in terms of safer blood and so on. Some estimates that I've seen are going to be pushing it up in the next year or so by

$100 to $150 a pint, in terms of the cost of blood supplies.

Where do we stick in new administrative regulatory burden? You've got all of the HIPAA stuff, confidentiality stuff, the administration figures for privacy requirements that they announced recently. I've seen estimates on that that run from a $43 billion impact for Blue Cross, in terms of implementing it, which I'm sure is on the high end -- no? Well, then that scares me for hospitals, because HCFA has estimated it would only be $71 million for all the hospitals in the United States, and I think it's going go be a lot more than that.

So just sort of looking at my environment, I can come up quickly with four or five things that I think are going to have a major impact in the next year or two that aren't accounted for here. So I'd just throw those out to you as you come back in March or April, and maybe you can do a little research on those.

MS. ROSENBLATT: I just want to follow up on what Spence said on a couple of things. First of all, on that regulatory burden and HIPAA, I do think there's probably major impact there.

The Blue Cross Blue Shield Association actually

used an external consulting firm to do that study. It was the Nolan Company. So there may actually be some data there that the Commission could pick up because there's probably a way to take what was done for the insurance industry and look at the providers.

On the Y2K thing, I end up in a different direction than you do, Spence. I mentioned before, I think there probably will be some productivity improvement from the upgraded equipment and other things, upgraded computer systems themselves, the logic has been improved, and things like that.

But I also view a lot of the Y2K expense as a one-shot expense, not an ongoing expense. So if you do take Gail's approach of it's kind of in the base, then there should be some stuff coming out of it.

But I also agree that it may not be over. I mean the computer experts I know tell me the next date to look at is the leap year date. So maybe by the March meeting we'll know if it's truly over or not.

DR. WILENSKY: Again, when I mention that it was in the base, at least to the extent that there was some acknowledgement in the actual update that was used, it was

to say it gives you a little additional cushion. You could also argue it even gives you a right to subtract it. But I think it's important to understand that it at least gives you a little bit of a cushion to the extent again you think it was in that spread.

DR. LAVE: This is a follow-up on what goes in and what goes out of the base, and it has to do with how we ought to think about the fact that the Congress does not accept our recommendations on where the rate should be sometimes.

If we are higher than the Congress, because of say our expectations on the S&TA factor, do we come back the next year and try to put it back in again? Or basically the Congress didn't like that S&TA factor?

I'm just thinking here about how we ought to think about these things, whether or not we want to or not, what's going on over time, just for some sort of intellectual, I don't know, purity.

The other thing, of course, that we can do is I think we have to take that route if we're going to take something is in and out of the base. Otherwise, we sort of start with where we are and sort of say looking forward,

what do we think is going to happen?

But I think if we're going to start taking things and talking about some stuff being in the base and we didn't haul it out, then we have to recognize that we wanted to put some stuff in the base and the Congress didn't put it in. So I just think that --

DR. NEWHOUSE: Judy, I think implicitly we are treating all the difference between what we said and the Congress did as site of care, or at least our point estimate. The range sort of fuzzes this, as well. So until we run out of the site of care adjustment, we've dodged your question.

DR. LAVE: That's fine with me, too. I just want to make sure.

DR. WILENSKY: I don't know if we have to make this decision not only not today, but not this cycle. But I think that the Y2K is somewhat different because even in conceptually thinking about it, we make projections about what we think is going to happen in the future. So while it is true that the Congress may not adopt it, it's also very likely that we misguessed what it was that was going to happen in terms of scientific and technological innovation

and implementation.

So I think there can be a rationale for saying we're not going to go back to get it out of the base. We're not going to try to go see whether we forecasted accurately. We do the best we can.

The only reason I think that Y2K struck me is different is that we really have thought about a lot of the Y2K as, if not one-time only, something very different going on, although it was in part replacing normal replacement expenditures for computer and support. Even if it's more than machinery, when you would have done a lot of this replacement you would have done a lot of the support.

And to the extent that it reflected much more of a one-time shot, then the fact that it does continue in the base is somewhat different. So I'm not suggesting that we go and try to correct the base or try and correct our projections. I just think that it's a little different here because this was regarded as major expenditure money, at a particular point in time, and it is different from our normal base issues.

But again, I don't think we have to make this decision.

MR. ASHBY: I'd like to in essence seek guidance on one of the technical issues here. I feel very between and betwixt by the point that Spence has raised. Because on the one hand I think we have to make clear that the S&TA was never designed to capture administrative things, like management time spent dealing with the privacy regs and the like.

But on the other hand, that's not to say that those aren't very real costs and one could consider it analogous to the factor for changes in law and regulation that we have in the SGR.

So I'm wondering how we should treat this. It does not seem, to me, to be something that we should ignore. But it does not fit in the S&TA. So should we make it fit? Create another one-liner for law and regulation factors? Or what?

DR. KEMPER: I think if we go back to the framework discussion, that middle category of technological change and so on needs to be an elastic category where --

MR. ASHBY: Where needed?

DR. KEMPER: Where there are specific items that vary, both by type of service and over time within a

service. So something might come in for a time that's an issue or not. That would be my view. I don't think that we should lock ourselves into rigid categories.

MR. ASHBY: I think that's a good point. We would just describe it as exactly what it is and say we're expanding the category to accommodate it.

DR. KEMPER: That's different from whether or not a specific adjustment is justified in this particular case.

MR. LISK: Just on a historical context from when ProPAC had done this when the AIDS epidemic really started breaking out and hospitals changed how some of their practices were going, in terms of treating all patients, just the increased use of rubber gloves. It wasn't technology but that was something that was put in the S&TA, even though it wasn't technology related.

DR. KEMPER: So we'll call that elasticity, too.

MR. LISK: So historically, that type of elasticity has been considered.

DR. KEMPER: I guess one issue it seems like we do have to talk about is this -- for lack of a better term, downcoding and whether there ought to be a negative adjustment there. I guess, to me, the logic says yes, there

should be. But I'd be interested in other people's view.

DR. NEWHOUSE: It wouldn't be a negative adjustment. It would be a positive adjustment.

DR. KEMPER: I'm sorry, positive -- the reverse of our --

DR. NEWHOUSE: My personal preference would be to treat it as -- we haven't been making much in the way of adjustments for upcoding, so maybe this is, in effect, something we just didn't adjust for in the past.

MR. ASHBY: We didn't make adjustments for upcoding. Oh yes, we did.

DR. NEWHOUSE: Each year?

MR. ASHBY: Not lately, but...

DR. NEWHOUSE: That's what I mean, not lately. So this is within the range of something that might have been upcoding lately.

MR. JOHNSON: So it's a statute of limitations on [inaudible].

DR. KEMPER: Then why we didn't make an adjustment? Just because it was so small?

DR. NEWHOUSE: As Tim said, the only data we had were from a decade ago, and the thing seemed to be

asymptoting out the way one would have thought it would have if there was no upcoding going on.

DR. KEMPER: I'm sorry, I misspoke. I mean the case mix index.

DR. NEWHOUSE: That's what we're talking about.

DR. KEMPER: That graph showed pretty clear evidence over time of the case mix index rising. Or did I misread that?

DR. NEWHOUSE: No. A couple of the bumped ups were times when we changed the group. Or the '88 bump was when we took out the age 70. And we've also introduced some high weight DRGs over time. Any time you change the group or in principle you get a bump.

DR. LAVE: What happened in '95?

DR. NEWHOUSE: I was trying to remember what happened in '95.

DR. WILENSKY: The problem, at least in having this conversation with Jack last night, is he's quite convinced in his hospital that it isn't a coding issue. He doesn't know what it is. He's not sure why it's happening and they have experienced a case mix decline. But given the incentives that they have at their hospital, he doesn't

believe that it is a downcoding.

If we get a sense about what we think it is, we can consider an adjustment. I think the problem is do we have, on the basis of one observation, a sense of what kind of adjustment we would want to make. I think the answer is it's going to be pretty hard to do that. And maybe there's something that's going to come along between now and March, but it would be hard for me to imagine a whole lot that we'd want to say this explains what is a perplexing drop.

Maybe there is some estimate but at least, again, the conversation we had is he quite strongly things -- at least in his one institution -- that's not what's going on. Maybe there will be some estimate somebody else makes about how much of the CMI change might be downcoding.

DR. LAVE: I think there also is a difference between downcoding and more accurate coding. That's a different thing. And I think if one looks at the data that we're presented on the infectious diseases and pneumonia, ones prior might be that that was a shift towards accurate coding.

So there really is a difference between -- any adjustments for more accurate coding I don't think one would

want to take into consideration. Sort of explicit downcoding because I'm scared of the big bad Feds would be different.

MR. GREENE: We will have some data, we hope, from this data [inaudible] Rand study.

DR. WILENSKY: Will that be ready in time for our recommendation?

MR. GREENE: Yes.

DR. WILENSKY: We will come back to this issue at that point.

MR. ASHBY: We were carrying on a side conversation here. Another point of clarification is that the S&TA does include drugs as new technologies. The market basket, of course, accommodates increases in drug prices but they are increases in existing drug prices. But we have indeed included new drugs in the S&TA estimates. We have been all the way along.

DR. NEWHOUSE: Wouldn't the market basket accommodate Spence's blood example, as well?

MS. RAY: When there's a new technology or new advancement --

DR. NEWHOUSE: I understand, but presumably we had

a price for blood before.

DR. LAVE: Is blood a covered Medicare service? Doesn't Medicare --

DR. NEWHOUSE: In the hospital.

MR. ASHBY: In the hospital, yes.

MR. JOHNSON: [inaudible]

DR. WILENSKY: You can provide us, if you want, with some -- my sense is that it is in the indices that we're looking at, from what you're saying.

We have two more recommendations we're going to need to revise, but if there are other suggestions you want to make to Tim before we leave this issue, this would be the time to do it.

DR. LAVE: I have a question about how we think about prices, and I'm glad Carol is still here, which has to do with sort of thinking about updates for things like home health and SNFs. That is how the market for auxiliary services, how those wage rates get affected in what's happening in wages. Let me try to be more articulate.

In the Pittsburgh area, because of the very strong market, there's been a decrease in people who want to work in home health agencies and SNFs and so forth. And so

there's been much more of a use of people who come through agencies. The implication of that, at least in Pittsburgh, is that you pay about twice as much for somebody who you hire through an agent than if you hire by yourself.

I don't know if this is generic or if this just happens to be a Pittsburgh issue. My sense was that this was an increasing problem in very tight labor markets, what to do about workers who have now much more increased options and much more of a use on agency until you worry about how to change your benefits which is, for reasons, quite complicated.

So the question that I have is, in terms of looking at updates, does this shift to -- if this is happening in places other than the Pittsburgh market -- would this shift to agencies be picked up in the way we adjust for wages if that is a problem that SNFs and so forth are handling?

DR. WILENSKY: In principle, it should be. But since we know, for example in home care, we don't have the right price -- well, we have a questionable wage index that we're using, and SNFs too. In principle, if we had the right wage index, we would have that.

MR. PETTENGILL: Be careful to distinguish between the wage proxies that are used in the market basket from what's used in the [inaudible]. The wage index for geographic adjustment is based on including or contract labor. So if they hire from an agency it shows up in the other hand in the update. The wage index proxies are BLS proxies that are employment cost index that are not specific.

DR. LAVE: So this would be a problem, whether or not it's a generic issue. As I said, I don't know whether it's a generic problem, some other people who have issues. But if it is a problem with tight labor markets and a shift to agencies, it may be something that we ought to be able to say something about.

DR. WILENSKY: Nancy?

MS. RAY: I am back with revised recommendations for the Commission to take another look at.

The first revised recommendation is with reference to risk adjustment payments for patients with ESRD enrolled in Medicare+Choice. I think this language took into account the Commission's desire for HCFA to risk adjust payments now using all available data that's available. And that this

methodology should be developed as soon as possible.

The second draft recommendation is a new one, and this one specifically addresses the issue of when ESRD beneficiaries are in Medicare+Choice plans and the plan leaves the area. They cannot enroll in another Medicare+Choice plan. So ESRD beneficiaries who lose Medicare+Choice coverage because their plan leaves the area should be permitted to enroll in another Medicare+Choice plan.

The last new recommendation is directing HCFA to collect information on the satisfaction of ESRD beneficiaries, specifically with the goal of collecting satisfaction about the quality and access to care.

DR. WILENSKY: Let me make a suggestion on the date. We've been talking about whether we wanted to put a specific date in. We have not had an opportunity to specifically raise that with HCFA. I think we make our intent clear on recommendation one. It's not like they're going to listen particularly anyway.

So my suggestion is since we haven't extended them the courtesy of saying is there a reason why there would be a problem with fiscal year 2001, that we leave it without

having that specific date. Because I think the way you've phrased it makes our intent quite clear. If people are comfortable with that.

Can you put the first one back up? My comment had to do with the first one.

I think that developed the sense of urgency that we had in mind, and I'm comfortable without the date, as somebody who had been toying with the notion, because we have not checked.

The second one. I think that was also the issue that Bea raised yesterday and I think that clearly states it.

DR. LONG: Another thought occurred to me. What if a beneficiary leaves the area and goes to another area where there is a Medicare+Choice plan? Are they permitted to re-enroll there? I move from Columbus, Ohio to Phoenix?

DR. WILENSKY: I understand the issue. I think that's just maybe more than we want to get into until we have gotten to the second stage. It is a variation on this, but it is taking it a little farther.

My own preference is this one seems a no-brainer. Once you start moving areas and different plans that are

likely to be there, I'm a little less comfortable until we get to the stage of our first recommendation.

It's a fair question but I think I'd just leave it as it is. I saw people nodding their heads. Are people comfortable with that?

The third one. The only issue is I think it's not just information on the satisfaction of the ESRD beneficiaries, but with some specified outcome measures. And then otherwise, it's fine. I think you've covered well our discussion.

Thank you, Nancy. I was a little concerned because I thought we were clear where we wanted to go, but I wanted people to have a chance to see the wording, since it was a recommendation.

We meet again March 16th and 17th, here. This has been a productive day, as was yesterday. We look forward to having additional information presented.

MR. SHEA: Can I just say thanks to the staff for what I thought was great work and congratulations on producing so much of it so quickly. High productivity, which maybe should lead to an adjustment downward.

MS. ROSENBLATT: Are we going to need to review stuff again? What's the schedule?

DR. ROSS: We will be sending some additional materials back to people. I think we need to, at the staff level, reconvene with what we've heard here. We mentioned a lot of moving parts, in terms of chapters. Once we see what we have, we'll figure out what to get to people.

MS. ROSENBLATT: My point of view, the less I'm sent the happier I'll be. And if I'm going to be sent anything, the sooner the better.

DR. KEMPER: In any case, once you regroup and figure out what we can expect, could you just send us an e-mail, so that we have some idea what's coming when, roughly speaking?

DR. ROSS: Yes, that should happen probably Tuesday.

DR. WILENSKY: Follow on public comments?

MS. LAUERHAAS: Yes, just briefly, in follow up to a discussion you had a minute ago, my name is Teresa Lauerhaas and I'm general counsel and director of government affairs for the American Association of Blood Banks. I'm here today on behalf of a coalition of groups interested in

blood related issues, including AABB, America's Blood Centers, the American Red Cross, the American Society for Aphoresis, the American Society of Hematology, and the College of American Pathologists.

We had planned to come here today just to put in a word about an issue that we wanted to raise to the committee, and that is the need for Medicare to better address and to ensure fair reimbursement for blood-related products and services.

This comes up in light of that blood safety and availability is a clear national public health priority, as recognized by the Department and Congress and the public. As we move forward with new safety measures that are increasingly expensive, it is important that Medicare reimburse fairly for these services and products.

We're concerned that there's not an adequate mechanism in place to ensure these payments, and therefore we'd like to have the committee look at this issue. We'd request you to consider addressing it at future meetings and making recommendations about Medicare payments, particularly in the inpatient PPS system.

We have concerns about lags in both payments and

coding for blood products and services and we, as a coalition of groups, look forward to working with you and would be happy to provide you with additional information so that we can work together to ensure that patients have access to the safest possible and highest quality blood services and products.

DR. NEWHOUSE: Thank you. Any other public comment?

MS. WILLIAMS: Deborah Williams, AHA.

Joe, when I was flogged in my economic classes, what they taught me was the Lispairs is a fixed weight price index that excludes all quality and intensity effects; correct?

That's why, as you know, the CPI and the PPI --

DR. NEWHOUSE: Depends on what the BLS is doing on a particular index, but go ahead.

MS. WILLIAMS: That's why, for example, in the CPI and PPI, they only include one-fifth of new drugs every year, which is why people have the impression, as you know, new drugs are about twice the cost of old drugs. That's why the CPI and PPI are fairly stable at 3 percent because, of course, they sort of depress it to keep out the quality

intensity effects.

Now as far as blood goes, I've spoken with the HCFA actuaries about it and theoretically the new blood tests, because of the quality intensity, should be out of the index. However, they also said, which you did, that the question is is BLS going to be paying attention when the price of blood shoots up by a third?

So with blood it's a little less clear than drugs that most drug costs are probably the new drug costs and intensity are not captured. Blood it's hard to say what's going to happen exactly.

My other comment would be on HIPAA and privacy, and I guess my comment there would be, Jack, I'm not sure I agree with you that it's a managerial effect. In fact, what HIPAA and privacy are all about is software and computer changes, enormous software and computer changes. Changes in the electronic transmission, changes in the size and numbering of the provider ID, goodness gracious, change on how you account for and code drugs. In such a way, they're so beyond Y2K on the computer side as to be enormous.

Thanks.

DR. NEWHOUSE: I agree on your point on drugs, but

that, in principle, in the S&TA.

MS. SMITH: I'm Kristin Smith with America's Blood Centers. I again wanted to express our support for the comments that Teresa Lauerhaas made from AABB and also to submit, for the record, a letter that we sent to the commissioners of MedPAC, again just stressing the need for perhaps looking into some remedy for blood products and services.

DR. NEWHOUSE: Thank you.

[Whereupon, at 2:27 p.m., the meeting was adjourned.]

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